MEDICATION PHYSICIAN ORDER AND PARENTAL CONSENT FORM

Student Name:______________________________DOB:____________Grade:________

Student Address:____

Name of Licensed Prescriber:__________________________Title:______________

Business Phone:__________________________Emergency Phone:_________________

Medication:____________________Dosage:______________Frequency:____________

Route of Administration:____________________Times of Administration:____________

*(Please note: whenever possible, medication should be scheduled at times other than school hours.)

Specific directions or information for administration:______________________________

____

Date of Order:____________________Discontinuation Date:________________________

Diagnosis*:____

Allergies or Other Medical Conditions*:______________________________________

Special Side Effects, Contraindications or Possible Reactions to be Observed:________________

____

Other Medication Being Taken by the Student:___________________________________

____

Consent for Self Administration (provided the school nurse determines it is safe and appropriate)

YES________ No________ ____

Signature of Licensed Provider Date

PARENTAL CONSENT:

Parent/Guardian Printed Name:____

Telephone Number (Home):____________________Cell:______________Work:______________

(circle the number to use for emergencies)

I consent to have the school nurse or other designated school personnel administer to my child,

______________________, **the medication prescribed by the licensed physician detailed above.**

(child's name)

I give permission for my son/daughter to self-administer this medication, **if the school nurse determines it is safe and appropriate.**

YES __________ NO__________

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve this medication from the school at any time; however, this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature:____

Relationship to Student:____

Address:______________________________________Date:______________________

*If not in violation of confidentiality