MEDICATION ADMINISTRATION ORDERS, CONSENT, AND PLAN OF CARE

Name: _____ DOB: _____ M/F

Name of Licensed Prescriber: _____

Diagnosis: _____

Medication: _____ Dosage: _____Frequency:_____
Is it absolutely necessary for this medication to be taken at school? Yes/No

Date of Order: _____ Expiration of Order: _____Expiration of Medication: _____
Quantity of medication received by the school nurse and date: _____

To be completed if not in violation of confidentiality.

Signature of Physician: _____ Date: _____

Parent Consent

(Please initial)

_____ Student should always take medication on a field trip.

_____ The school nurse may administer the medication ordered above. (i.e. epipen)

_____ Student may self-administer medication (such as inhalers) at school and/or field trips.

_____ The school nurse may share with appropriate school personnel, information relative to the prescribed medication administration. (i.e. Adverse side effects as the nurse determines necessary for the student's health and safety.)

Please note: I understand that I may pick up the medicine from school at any time, but the medicine will be destroyed if it is not picked up within one week after the physician's order expires or one week beyond the close of school.

Parent/Guardian (please print): _____ Telephone: _____

Signature of Parent/Guardian: _____Date: _____
Relationship to student: _____

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