PHYSICIAN'S ORDER FOR MEDICATION ADMINISTRATION
(Please type or print)

Date ______________________

Re: ***Administration of Medication*** to: ______________________________________

Dear Dr.______________________________:

Pursuant to the request of ___________________________________, the parent/guardian of
______________________________________, the following individual(s) has/have been identified to administer medication to the above referenced student in the school setting:

____

____

In order to proceed with the administration of the medication you have prescribed, and to ensure that you retain the power to direct, supervise, decide, inspect, and oversee the administration of this medication, please complete the following form. Direct and address this information to the individual(s) identified above.

Please note that your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designees specified on this form, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

Please feel free to call if you have any questions.

____
School Principal or other school designee

TO BE COMPLETED BY PHYSICIAN

To: ____
(Person designated to administer medication)

Name of Student ____________________________________ Phone Number __________________

Address ____
School ____ Grade _________________

Physician's Name ____________________________________ Phone Number _________________

Physician's Address ____

Diagnosis ____

____

Medication/dose/route/frequency/duration _______________________________

Medication/dose/route/frequency/duration _______________________________

Check One: Short term _________ Long term _________

PRN (as the situation demands) Medications: ___________________________

Medication/dose/route/frequency/duration _______________________________

Medication/dose/route/frequency/duration _______________________________

If a PRN medication, the conditions under which medication is to be given are as follows:

____
____
____

Check One: Short term _________ Long term _________

The specific conditions under which contact should be made with me in relation to the condition or reactions of the student receiving the medication are as follows:

____
____
____

____ ___________________
Physician's Signature Date

PARENT/GUARDIAN MEDICATION CONSENT FORM
(Please type or print)

Full name of child to be medicated ____

Name of drug and dosage ____

Hour(s) medication to be given ____________________________ Number of days __________

Name of Student's Physician ______________________________ Phone __________________

Reason for medication ____
(if applicable)

Name of person(s) authorized to give medication during school hours ______________________

____
(to be filled out by school principal or program administrator other designee)

My child has permission to self-administer the medication, but I request school staff monitor or assist my child when he/she self administers medication on the following basis: ____
____
(indicate if not applicable)

I hereby give permission to the above named person(s) to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician, if necessary. I agree to hold the school, its employees an agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication at school.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

____ ____________________
Signature of Parent/Legal Guardian Date

____
Address

NOTE

Before a prescription drug(s) or medications(s) will be administered by the school or an agent thereof, a PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION shall be completed and returned to the school principal. This completed form shall be accompanied by the PARENT/GUARDIAN MEDICATION CONSENT FORM. This form (Parent/Guardian Medication Consent) must also be completed for the administration of non-prescription (over-the-counter) drug(s) or medication(s) which do not require the Physician Order.