

**PHYSICIAN'S MEDICATION ORDER FORM**

This order is valid only for school year (current) \_\_\_\_\_ School \_\_\_\_\_

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

Please review Medication Guidelines on back of form.

**PRESCRIBER'S AUTHORIZATION**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

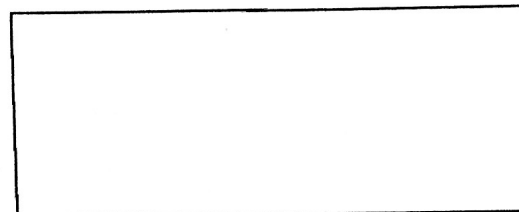
Time/frequency of administration: \_\_\_\_\_ if PRN, frequency: \_\_\_\_\_

If PRN, for what symptoms: \_\_\_\_\_

Relevant side effects: ☐ None expected ☐ Specify: \_\_\_\_\_Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year*If above dates are not completed, medication will be administered until the end of the school year*Prescriber's Name/Title: \_\_\_\_\_  
(type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): \_\_\_\_\_ for the above medication on (Date): \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse. **PLEASE NOTE: An emergency medication contract must be signed by a health care provider, reverse side must be completed.**

Prescriber's authorization for self carry/self administration of emergency medication: \_\_\_\_\_  
Signature DateSchool RN approval for self carry/self administration of emergency medication: \_\_\_\_\_  
Signature DateOrder reviewed by the school RN: \_\_\_\_\_  
Signature Date☐ NKDA (No known drug allergies)

ALLERGIC TO: \_\_\_\_\_

**PHYSICIAN'S MEDICATION ORDER FORM**Attach  
Photo**TO BE COMPLETED BY PARENT/GUARDIAN**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

◆◆◆ PLEASE USE A SEPARATE FORM FOR EACH MEDICATION ◆◆◆

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER**

Name of medication: \_\_\_\_\_ Allergies: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Form of medication/treatment:

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other \_\_\_\_\_**Instructions** (Time to be given at school): \_\_\_\_\_

Dose (mg, ml, ml/tsp, # puffs) \_\_\_\_\_ Route \_\_\_\_\_

If PRN, for what symptom(s) \_\_\_\_\_

**Side effects:** (Please describe) \_\_\_\_\_

Please check one of the following:

Discontinue: ☐ End of school year ☐ Other (specify): \_\_\_\_\_◆◆◆ Please note: Any deviation from the scheduled time requires a new order. ◆◆◆  
This includes delayed openings, early dismissals or field trips.

Authorized Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Prescriber's Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(Type or Print)

A verbal order was taken by the school RN (name) \_\_\_\_\_ for the above medication on (date) \_\_\_\_\_

Verbal order must be followed by a signed order within 3 days.

## ◆◆◆ For Self-Administration ONLY ◆◆◆ For Self-Administration ONLY ◆◆◆

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER****TO BE COMPLETED FOR INHALER OR EPI-PEN ONLY**

Washington County Board of Education permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions. Completion of the following information by the authorized prescriber acknowledges that this student has been instructed and has the skills and knowledge on self administration of this medication.

This student may carry this medication: ☐ No ☐ Yes

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Authorized Prescriber's Signature)

◆◆◆ PARENT TO COMPLETE EPI-PEN/INHALER CONTRACT ON BACK OF THIS FORM ◆◆◆

**TO BE COMPLETED BY PARENT/GUARDIAN**I give permission for (name of child) \_\_\_\_\_ to receive the above stated medication at school according to standard school policy. I release Meritus Health and Washington County Board of Education and their employees from any claim or liability for administering prescribed medication to this student. **I HAVE READ THE INFORMATION OUTLINED ON THE BACK OF THIS FORM AND ASSUME THE RESPONSIBILITIES AS STATED ON THIS FORM. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Emergency phone: \_\_\_\_\_

Order reviewed by the school RN \_\_\_\_\_ Date \_\_\_\_\_  
Form M-1 (08)