WASHINGTON COUNTY HEALTH DEPARTMENT WASHINGTON COUNTY PUBLIC SCHOOLS

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: _____ (Month/Day/Year) **to** _____ (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: _____ (Original signature or signature stamp ONLY) Date: _____

(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 Date

School RN approval for self carry/self administration of emergency medication: _____ Signature Date

Order reviewed by the school RN: _____ Signature Date

☐ NKDA *(No known drug allergies)*

ALLERGIC TO: _____

Attach Photo

MERITUS HEALTH SCHOOL HEALTH PROGRAM WASHINGTON COUNTY PUBLIC SCHOOLS

PHYSICIAN'S MEDICATION ORDER FORM

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 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)