Medication Order Form

Student's Name: ____ Grade:__________

DOB:___________ Weight:_______________ Allergies:_________________________

Medication Orders:

Medication Name:	Dose, Frequency, and Route of Administration:	Time of Admin:	Diagnosis:

Level of assistance (see descriptions on back): _____Independent _____Supervised _____Nurse Dependent

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Parental Permission: 1) I request that my child receive the medication as prescribed above while at school or school sponsored activities. **2)** For medications that require rapid administration AND have been checked off as "Independent", I agree that my child can self-administer the medication(s) safely and effectively, and may carry and use this medication (with a delivery device if needed) independently. Staff intervention and support is needed only during an emergency.

Parent/Guardian (Print):________________________________Parent/Guardian (Signature):_______________________Date:_____________

Healthcare Provider Orders: 1) I request that this student receive the medication as prescribed above while at school or school sponsored activities. **2)** For medications that require rapid administration AND have been checked off as "Independent", I attest that this student has demonstrated to me that he/she can self-administer the medication(s) safely and effectively, and may carry and use this medication (with a delivery device if needed) independently. Staff intervention and support is needed only during an emergency.

Healthcare provider signature:_________________________________Date:_____________

Providers Name, Address, Phone (or stamp to the right):______________________________

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