the education COOPERATIVE

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Medication Order Form 2016/2017

Must be completed by a licensed prescriber

★★ Please complete one form for each medication to be given at school ★★

Name of Student: ______________________ **Date of Birth:** ______________

Address: ______________________ **Grade:** ______________

Parent/Guardian: ______________________ **Emergency Phone:** ______________

Name of Licensed Prescriber: ______________________

Prescriber Telephone: ______________________ **Prescriber Fax:** ______________

Medication: ______________________ **Allergies:** ______________

Route of Administration: ______________________

Dosage: ______________________ **Frequency:** ______________

Time(s) of Administration: ______________________
(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Specific directions or information for administration: ______________________

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Date of Order: ______________________ **Discontinuation Date:** ______________

Diagnosis*: ______________________
* If not in violation of confidentiality.

Optional Information
1. Special side effects, contraindications, or possible adverse reactions to be observed: ______________________

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2. Other medication being taken by the student: ______________________

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3. The date of the next scheduled visit or when advised to return to prescriber: ______________________

Physician
Consent for Self-Administration (provided the school nurse determines it is safe and appropriate) **Yes______ No____**

____
Signature of Licensed Prescriber and date

Parent/Guardian
I understand that I may retrieve the medication from the school at any time. *However, the medication will be destroyed if it is not picked up within one week following the termination of the order or one week beyond the close of school.*

Consent for Self-Administration (provided the school nurse determines it is safe and appropriate) **Yes______ No____**

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Signature of Parent/Guardian and date