One Family in Christ Jesus

MEDICATION ORDER FORM
Signed Original Order Required

Student Name: _____ Grade: _____

Provide a separate form for each medication that is to be administered.

PRESCRIBER TO COMPLETE:

Medication: _____

Dosage: _____ Route: _____ Frequency: _____

Indication: _____

Special Instructions: _____

Precautions/Side Effects: _____

_____ _____
Date Prescriber's Original Signature (No Stamps Please)

Prescriber's Name: _____
Address: _____
_____
Telephone #: _____

Please note: A school nurse may not always be available during school hours to administer this medication. This medication order is effective July 1 - June 30 of each school year and must be renewed annually.

I give permission for (name of student)_____ to receive _____ at school as prescribed above by _____.

I WILL BRING THE MEDICATION PRESCRIPTION OR NON PRESCRIPTION TO SCHOOL IN THE ORIGINAL PROPERLY LABELED CONTAINER.

_____ _____
PARENT/GUARDIAN SIGNATURE Date