

School Year _____

PHYSICIAN'S ORDERS FOR PRESCRIPTION MEDICATION TO BE GIVEN AT SCHOOL

Student's Name _____ Age _____ Grade _____

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE: _____

FREQUENCY: _____

POSSIBLE SIDE EFFECTS: _____

LENGTH OF TIME MEDICATION IS PRESCRIBED: _____

This child may self-administer medication for field trips, with supervision, or if the school nurse is not available.

Yes

No

Parent/Guardian Signature _____ Date _____

Physician's Signature _____ Date _____

PLEASE NOTE: Potentially life-threatening conditions (i.e. asthma, severe food allergy, diabetes) should be accompanied by an Action Plan. All medications and an Action Plan must be submitted before the start of school. Diabetes also must have a specific action plan submitted by their doctor. Please feel free to call Nurse Stabler to discuss any medical concerns.