

**MEDICATION ORDER**

**(TO BE GIVEN BY SCHOOL NURSE)**

School Year \_\_\_\_\_

No medication will be administered without BOTH the written order from the physician and the parent.

**PHYSICIAN, PLEASE NOTE:**  
**Do not leave any blank spaces.** This form will be returned to you and may cause a delay in the administration of your patient's medication.

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Route:** \_\_\_\_\_ **Time(s):** \_\_\_\_\_ **Total dose(s) per day:** \_\_\_\_\_

If PRN provide criteria: \_\_\_\_\_

Precautions/side effects, if any (i.e. No heights or climbing ladders, no waterway activities-risk of drowning, etc.):  
\_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician's name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Printed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_  
\*\*\*\*\*

**Parent/Guardian completes this section:**

I give permission for the school nurse to administer the above medication, as prescribed by my child's physician, to my child, \_\_\_\_\_. I understand that no medication will be given to my child unless it is brought to school in the original container, properly labeled, from the pharmacy/manufacturer

**Parent/Guardian Print Name:** \_\_\_\_\_

**Parent/ Guardian Signature:** \_\_\_\_\_

**DATE:** \_\_\_\_\_