Physician Order for Administration of Medication by School Personnel

Date: _____ Student's Birth Date: _____

Student's Name: _____

Condition/Illness for which drug is to be given: _____

THE MEDICATION(S) LISTED BELOW MUST BE ADMINISTERED DURING SCHOOL HOURS AND CAN NOT BE SCHEDULED ANY OTHER TIMES:

Medication: _____

Dose: _____ Duration: _____

Route (circle one): Orally Inhalation NG/Gtube Topical Ears Eyes

Method and Time(s) of Administration:

(include special instructions, possible reactions, if any, etc.)

_____

_____

The student can self-administer the medication. Yes No (Circle one)

DOSAGE CHANGE REQUEST Medication: _____

Change to: _____

***NOTATION TO PHYSICIAN**:

1. Will this medication affect the student's psychomotor function and limit his/her ability in class? For example: Drivers Ed/Shop Yes _____ No _____
2. Please request pharmacist to label bottle/inhaler, etc. in addition to the box label.
3. RN may need to contact physician in writing or by phone.

NON-LICENSED PERSONNEL MAY BE ADMINISTERING THIS MEDICATION.

Physician's Name: _____ Phone: _____
(please print)

_____
Physician's Signature

As the parent or legal guardian of the above-named child, I have read the policies pertaining to school personnel administering prescriptive medication and this is your permission to administer the above medication to my child according to the physician's order written above.

*****IT WILL BE THE PARENT/GUARDIAN'S RESPONSIBILITY TO PICK UP THE MEDICATION FROM THE CLINIC OR GIVE WRITTEN AUTHORIZATION FOR THE SCHOOL TO RELEASE THE MEDICATION. EMPTY BOTTLES CAN BE SENT HOME WITH THE STUDENT. PLEASE REFER TO THE KISD MEDICATION PROCEDURE FOR ADDITIONAL INFORMATION.**

Parent's Signature: _____ Date: _____

Parent's Home Phone: _____ Business Phone: _____

Filed in clinic/office on _____ by _____

Revised 04/04