Medication Order and Parent Permission

Parents/guardians must fill out the top portion completely for any medication to be given in school. Doctors/prescribers should complete the lower portion of the form or fax a doctor's order to the Main Office.

Parent/Guardian Section: (to be completed and signed by a parent/guardian)

Student Full Name: _____

Student Grade Level: ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Student Date of Birth: _____ / _____ / _____

Parent/Guardian Full Name: _____Day Phone Number: _____

Food or Drug Allergies Held By Student: _____

Name of medication(s) to be given at school: _____

Other medications being taken by the student: _____

I give permission to school nurses and administrators to: (1) delegate or administer medication as prescribed by my child's healthcare provider, (2) share information relevant to the prescribed medication as determined appropriate for my child's health and safety, (3) determine if self-administration of medication is safe and appropriate for my child's health.

Signed:_____ Date: _____
(Parent/Guardian Signature)

Physican/Prescriber Section: (to be completed and signed by a licensed prescriber)

Patient Name: _____ Date of Birth: _____

Medication Allergies: _____

Provider Name: _____

Provider Telephone Number: _____

Date of Order: _____ Length of Order: _____

Name of Medication: _____ Dose: _____

Route: _____ Time(s) to be given at school: _____

Diagnosis (es): _____

Side effects or contraindications: _____

May child self-administer? YES / NO

Physician Signature: _____ Date: _____