



Medical Order Form

Student Name _____ DOB _____

Home Address _____

Licensed Medical Provider _____ Title _____

Phone _____

Date of Order _____ Discontinuation Date _____

Medication _____ Diagnosis _____

Route of administration _____

Dosage/Frequency _____

Time(s) of administration _____

Specific directions for administration _____

Special side effects, contraindications or possible adverse reactions or reactions if medication is not given: _____

Storage: _____

Consent for self-administration by student (with approval of parent/guardian and school nurse)

Yes _____ No _____

Signature of Medical Provider _____ Date _____

I request that the medication, named above, be given to my child. The medical provider explained, to me, the medication, its purpose and possible complications.

Parent/Legal Guardian's signature _____ Date _____

Parent/Legal Guardian's signature _____ Date _____