MEDICATION ORDER FORM 2019
For Prescription and Over-the-Counter Medication

Physician Please Note: This form is for one child and one drug only. Please use separate sheets for more than one drug and for other family members. *Remember, whenever possible, medication should be scheduled at times other than school hours.*

Name of Student: _____ Date of Birth: _____Grade: ___

TO BE COMPLETED BY LICENSED MEDICAL PRESCRIBER

Name of Medication: _____

Tablet/capsule Liquid Inhaler Nebulizer Injection Other: _____

Route of Administration: _____ Dosage: _____Frequency: _____

Times of Administration (regular school hours): _____ __ ____

Specific directions or information for administration: _____

Start Date: _____ Discontinuation date: unless otherwise noted* _____

**Please note: Orders are for camp season only and all orders are discontinued on 8/17/18*

Diagnosis for which medication is prescribed: _____

Other medical conditions*: _____
**If not in violation of confidentiality*

Special Side effects, contraindications, or possible adverse reactions to be observed: _____

Other physician orders concerning this medication administration: _____

Other medication(s) being taken by student: _____

Consent for self-administration of emergency medication. Only emergency medication such as epipen(s) and/or asthma metered dose inhaler for severe asthmatic is allowed. At the discretion of the parent, licensed provider, and camp nurse, this student may carry and self administer emergency medication listed above, with appropriate follow-up with camp nurse/personnel. *(No student may carry or self administer any psychotropic or controlled medication).* Contract to carry form is to be completed with school nurse.

☐ No Self administration

☐ May Self Administer Under this condition: _____

☐ May Self Administer Unsupervised, with a contract:

☐ May self administer for Field Trips only, with supervision

_____ _____

Printed Name of Licensed Prescriber Signature

Address: _____ Date: _____

Business Phone: _____ Emergency Phone: _____ Fax #____