PUPIL MEDICATION ORDER

I hereby request the School Nurse to give_____
The medication prescribed according to the written instructions below. This student would not be able to attend school if the medication is not administered during school hours. He/she is free of contagious disease and physically fit to attend school.

Diagnosis:

Name of Medication:

Dosage:

Time of Administration:

Time medication will be discontinued:

Potential Side Effects:

Restrictions this medication might have on the student's activities:

If PRN, under what conditions is the medication to be used:

May medication be repeated and how often:

Please list other medications child receives that might enhance, alter or impact the effects of this medication (including over the counter medicine):

Date: _____ MD Signature:_____

I hereby request the school nurse to give_____
The medication prescribed according to the written instructions above. I understand that the nurse and physician will communicate with one another as needed in order to safely and effectively carry out these medical orders. I further understand that this releases the school personnel from liability should a reaction result from the medication.

Date:_____ Parent Signature:_____