Wood County Schools
Health Services
1210 13th Street
Parkersburg WV 26101

School _____
Phone _____
Fax _____

MEDICATION ORDER FORM

Valid for the current school year for prescribed or non-prescribed (over-the-counter) medication. If any change in medication, dosage, time, or route is needed, a new Medication Order Form must be received <u>before</u> medication can be administered by school personnel.

CONFIDENTIAL

Student Name _____
Last First Middle
Birth Date ____/____/____ Grade _____ Age _____ School _____

Parent/Guardian Name (PRINT) _____

Parent/Guardian Phone (Cell) _____ (Work) _____ (Home) _____

<u>SECTION I – To be completed by licensed prescriber</u>

USE ONE FORM FOR EACH PRESCRIBED OR NON-PRESCRIBED (Over-the-counter) MEDICATION

Medication _____ Diagnosis/ICD-10 Code _____

Dosage _____ Time of Administration* _____

☐ *School nurse/designated school personnel may administer medication on a delayed schedule when school is delayed.

Method of Administration _____

Intended effect of medication _____

Name and Title of Licensed Prescriber (PRINT) _____

Address _____

Phone _____ Fax _____

Licensed Prescriber Signature _____ Date _____

<u>SECTION II – To be completed by parent/guardian</u>

Total dosage of this medication to be given in 24-hour period _____

This medication at this total daily dosage has been given at home, and my child did not demonstrate any adverse effects.

Other medications taken _____

☐ Check this box and use back to provide additional information as needed.

Medication Allergies _____

The licensed prescriber has discussed with me the risks and benefits of this medication at this dosage and course of treatment.

I understand the licensed prescriber may be contacted concerning medication order for reasons including, but not limited to, clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.

I understand that, with due notification of licensed prescriber and parent/guardian, the school nurse/Wood County Schools may discontinue medication administration if child's health appears to be at risk.

I understand that medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.

I understand a photograph of my child may be taken to assist in the correct administration of medication.

I hereby give permission for my child to receive medication at school as ordered by my child's licensed prescriber.

Parent/Guardian Signature _____ Date _____

Original: Comprehensive Student Health File