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.

Student Name						
Birth Date		/	Last Grade	Age	First School	Middle
Parent/Guardia	n Name	e (PRIN	T)			
Parent/Guardia	n Phone	e (Cell)		(Work)	(Home)
SECTION I – T	o be co	mplete	d by license	ed prescribe	r	
						ver-the-counter) MEDICATION
Medication				Diag	nosis/ICD-10 Code	9
Dosage Time				Time	of Administration*	
□ *School nurse	/designa	ated sch	ool personnel	may administ	er medication on a d	lelayed schedule when school is delayed.
Method of Admi	nistratio	on				
Intended effect	of medi	cation				
Name and Title	of Licer	nsed Pr	escriber (PR	INT)		
Address						
Dhama						
Phone				Fa	IX	
						Date
	riber Si	gnature				
Licensed Presc SECTION II – T	riber Sig o be co	gnature mplete	ed by parent	/guardian		Date
Licensed Presc <u>SECTION II – T</u> Total dosage of th This medication a	riber Sig o be co his medic it this tota	gnature mplete cation to al daily c	e d by parent be given in 24 losage has be	/guardian 1-hour period en given at ho	me, and my child did	Date I not demonstrate any adverse effects.
Licensed Presc <u>SECTION II – T</u> Total dosage of th This medication a Other medication	riber Sig o be co his medic at this tota s taken	gnature mplete cation to al daily c	ed by parent be given in 24 losage has be	/guardian 1-hour period en given at ho	me, and my child did	Date
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Original: Comprehensive Student Health File