HCPSS SCHOOL HEALTH SERVICES

Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)

Student Name: _____ Gender: M F Date of Birth: _____ Grade: _____ Date of Order: _____

School: _____ Order Expires End of School Year **or** (date): _____

Reason for Medication: _____ Order valid for current year including summer school (Check if appropriate) ☐

Name of Medication: _____ Dose: _____ Strength: _____

Time to Give Medication: _____ Route: _____ Frequency of Medication: _____ Date Med. Expires: _____

Possible Side Effects: _____ Allergies: _____

Special Instructions _____

☐ Student may carry and self administer medication for asthma or other airway constricting conditions MD Initials _____

PRINTED PHYSICIAN/PRESCRIBER NAME AND SIGNATURE	PARENT/GUARDIAN SIGNATURE

Medication Administration Record (For School Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
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June																															
July																															

Name/Position	Initials	Name/Position	Initials

Nursing assessement has been completed for student self-administration _____

Student may / may not self administer (Circle One) RN Signature Date

HCPSS/DSFCS/OSS/Health Services/Medication Order Form /pat/7/05