MEDICATION ORDER

(To be completed by a Licensed Prescriber)

Student's Name: _____ Date of Birth: _____

Diagnosis: _____

Medication: _____ Dosage: _____

Time(s) of Administration:_____ Route of Administration:_____

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

_____

Consent for self administration for Epi-Pen and/or Inhaler if school nurse determines it is safe and appropriate.

Yes _____ No_____

Date of Order:_____ Discontinuation Date:_____

_____ _____

Signature of Provider Address of Provider

PARENT PERMISSION

1. I give permission to have the school nurse administer the above prescribed medication to my child.
2. I give permission for my child to self administer if the school nurse determines it is safe and appropriate.
   Yes_____ No_____
3. I give permission for the school nurse to share with appropriate school personnel information relative to the prescribed medication as he/she determines necessary for my child's health and safety.
   Yes_____ No_____
4. I give permission for the school nurse to delegate the administration of this medication to designated school personnel for all field trips taken during this school year. I understand that the school nurse will notify me ahead of time as to the name of the staff that the medication will be delegated to.
   Yes_____ No_____

_____ Date:_____

Signature of Parent/Guardian

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St. Stanislaus School is a Roman Catholic, Franciscan, co-educational Pre-K through 8th grade school. Students are assisted in developing their potential spiritually, physically, and socially within a safe and diverse community. A foundation of academic excellence is created to prepare students to become contributing members of a global society.