Deal Elementary School

Student Medication Order

PLEASE HAVE THIS FORM COMPLETED BY YOUR STUDENTS HEALTHCARE PROVIDER FOR ANY MEDICATIONS YOUR STUDENT NEEDS TO TAKE DURING SCHOOL.

PLEASE NOTE - ONLY ONE MEDICATION PER FORM. If your student is prescribed more than one medication, please get additional forms from the school nurse. Thank you.

_______________________________ is being treated for _______________________________
(Name of Student) (Specific disease or complaint)

and is permitted to take the following medication at school:

Medication: _______________________________ Dose: ____________ (tabs - caps - puffs)

Route: ______________ Frequency: Every _____ hours
* PLEASE GIVE SPECIFIC TIMES AND DOSAGE, NOT A RANGE FOR EITHER

Duration Medication to be administered: School Year 20 _____ to 20 _____ OR

Short Term _______________________________

Adverse reactions to expect: _______________________________

Physician Stamp

____
Physician Signature Date

Authorization for School Nurse to administer above medication to my student is hereby given:

____
Signature of Parent/Guardian Date