

2010-2011 Prescription Medication Order

(Must be turned in with medication in pharmacy-labeled container)

Student's Name

Date of Birth

• To be completed by parent or guardian:

I request that my child _____ in grade _____ receive Medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, Ann Haddad, R.N., will administer the medication or an adult will supervise my child taking his own medication.

Parent/Guardian's Signature: _____ **Date:**

Phone - Home: _____ **Work:** _____ **Cell:**

• To be completed by the licensed health care provider:

I request that my patient, as listed below, receive the following medication:

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to be Taken During School Hours:

Duration of Treatment: _____

Possible Side Effects/Adverse Reactions (if any): _____

*This order form will be in effect for the 2010-2011 school year only. **These orders will not be valid without the Provider's Office Stamp below. Stamp should contain name, address, phone and license #.*

Provider's Signature

****Office Stamp:**

Date Ordered (**Order will expire on the last day of 2010-2011 school year.*)