Jefferson C-123 School District

MEDICATION ORDER FORM

This order is valid only for school year _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year for each medication, and each time there is a change in dosage, type, time, and route administration of a medication.

- Prescription medications must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about a child or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Name of Medication: _____

Tablet/Capsule ☐ Liquid ☐ Inhaler Nebulizer ☐ Injection ☐ Other: _____

Route of Administration: _____ Dosage: _____ Frequency: _____

Times of Administration (regular school hours): _____ Refrigeration needed? YES ☐ NO ☐

Specific directions or information for administration:

_____

State Date: _____ Discontinuation date (unless otherwise noted): _____

Diagnosis for which medication is being prescribed: _____

Drug Allergies: _____

Any special directions or possible side effects to watch for: _____

_____

Consent for self-administration of emergency medication. Only emergency medication such as epi-pen or inhalers.
At the discretion of the parent, licensed provider, and school nurse, this student may carry and self-administer emergency medication listed above, with appropriate follow-up with the school nurse.

☐ No Self Administration
☐ May Self Administer under this condition: _____
☐ May Self Administer for field trips only, with supervision.

_____

_____ _____

Printed Name of Licensed Prescriber Signature

Phone Number: _____ Fax Number: _____

A verbal order was taken by the school nurse, LPN: _____

I request the above medication or treatment to be administered to my child at school. I understand that I have the ultimate responsibility for providing the school an adequate supply of medication and for informing the school immediately if any information on this form changes.

Parent/Guardian Signature: _____ Date: _____

Medication Administration Daily Log
(To be completed for each medication)

School Year: _____

Student Name: _____ Grade: _____

School Name: _____ Name of Dispensing Pharmacy: _____ Rx #: _____

Name and Dosage of Medication: _____ Route: _____ Frequency: _____

Directions: Initial with time of administration; a complete signature and initials of each person administering medications should be included below.

	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
Aug.																															
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															

NOTE: Person administering medication should initial and sign below.

Initial	Signature	Initial	Signature
1. ____	_____	1. ____	_____
2. ____	_____	2. ____	_____
3. ____	_____	3. ____	_____
4. ____	_____	4. ____	_____

Codes

A) Absent
E) Early Dismissal
F) Field Trip
N) No Medication Available
O) No Show
W) Dosage Withheld
X) No School