

PHYSICIAN ORDER FOR PRESCRIPTION MEDICATION ADMINISTRATION IN SCHOOL
(To be renewed annually)

Student: _____ Date of Birth: _____ Grade: _____ School Year: 2021-22
Parent/Guardian(s): _____
School (circle one): Pioneer Elementary | Healy High School Height: _____ Weight: _____

PHYSICIAN ORDER

	Medication	Dosage	Time	Duration
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Diagnosis/Medical reason for medication: _____

Common side effects: _____

This student is able to independently use their inhaler or EpiPen correctly and may carry it with the. YES / NO

Provider signature

Date

Provider Name (PRINTED)

Provider phone number

Clinic: _____

Fax Number: _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above named medication(s) to be administered to my child during the school day as ordered by the medical provider.
2. I will immediately notify the school of any change in the medication or provider order, dosage change, frequency or duration of the medication.
3. I give permission for the school nurse(s) to communicate with other school personnel about the action and side effects of the medication.
4. I give permission for the school nurse(s) to consult with my child's medical provider concerning any questions that arise with regard to the listed medication(s), medical condition(s), or side effects of this medication.
5. Field trips – I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
6. I release all school personnel, ISD 484, and any responsible adult administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication(s).
7. All medications must be picked up on the last day of school by a parent/guardian. Any remaining medications will be delivered to the Pierz Police Department to be disposed of lawfully.

Parent/Guardian Signature

Date