Prescription Medication Order Form (To be completed by a physician, dentist, or nurse practioner)

Student Name:_____ DOB:_____ School:_____ Grade:_____

Reason for Medication)_____ Date of Order:_____ Date Order Expires:_____ Date Medication Expires:_____

Name of Medication:_____ Dose:_____ Time:_____ Frequency:_____

Route of Admin:_____ Additional Instructions:_____

Student Allergies:_____ **Physician /Prescriber Signature:**_____

I give permission for school personnel to administer this medication to my child (**Parent/Guardian Signature**) _____

Medication Administration Record (For School Use Only)

	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
August																															
September																															
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June																															

Name/position	Initials	Name/position	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Codes (used for unusual situations)

−:Weekend/holiday A: Absent

ED: Early Dismissal F: Field Trip

N: None Available O: Omitted

D/C: Discontinued R: Refused