Medication Form/Physician's Order (To be Completed by the Physician/Authorized Health Care Provider)

School: _____ Grade: ___ Date of Order: _____ Order Expires End of School Year or (date): _____

Student Name: _____ Order valid for current year/Summer (Check if appropriate): ☐

DOB: _____ Gender: M F Allergies: _____

Name of Medication: _____ Dose: _____ Route: _____ Time to Give Medication: _____

Reason for Medication: _____ Frequency of Medication (IF PRN): _____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

Parent/Guardian Name:	**Physician Name:**	**Phone:**
Phone:	**Address:**	
PARENT SIGNATURE:	**PRESCRIBER SIGNATURE:**	

Medication Administration Record (For School/Camp Use Only)

Nurse Reviewed: **Dates Reviewed:**

	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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July																															

Name/Position Initials Name/Position Initials

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____

RN Signature Date

CODES: Chart reason (See H.S. Manual)

X: School Closed FT: Field Trip

A: Absent R: Refused

N: None Available O: Omitted

NS: No Show to HR H: Dose Held

D/C: Med. Discontinued

L/E: Late Arrival/Early Dismissal

Revised 071415

HEALTH LINK LLC

Medication Administered (This side for school use only)

Student Name:

Date	Time	Student Complaint	RN Consulted ✓	Medication Administered as ordered ✓	Student Outcome	Staff Initials	Parent Notified ✓

Comments: