

PHYSICIAN'S MEDICATION ORDER FORM

Attach Photo

TO BE COMPLETED BY PARENT/GUARDIAN

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

◆◆◆ PLEASE USE A SEPARATE FORM FOR EACH MEDICATION ◆◆◆

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication: _____ Allergies: _____

Reason for medication: _____

Form of medication/treatment:

Tablet/Capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (Time to be given at school): _____

Dose (mg, ml, ml/tsp, # puffs) _____ Route _____

If PRN, for what symptom(s) _____

Side effects: (Please describe) _____

Please check one of the following:

Discontinue: End of school year Other (specify): _____

◆◆◆ Please note: Any deviation from the scheduled time requires a new order. ◆◆◆
This includes delayed openings, early dismissals or field trips.

Authorized Prescriber's Signature: _____ Date: _____

Authorized Prescriber's Name/Title: _____ Phone: _____ Fax: _____
(Type or Print)

A verbal order was taken by the school RN (name) _____ for the above medication on (date) _____

Verbal order must be followed by a signed order within 3 days.

◆◆◆ For Self-Administration ONLY ◆◆◆ For Self-Administration ONLY ◆◆◆

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

TO BE COMPLETED FOR INHALER OR EPI-PEN ONLY

Washington County Board of Education permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions. Completion of the following information by the authorized prescriber acknowledges that this student has been instructed and has the skills and knowledge on self administration of this medication.

This student may carry this medication: No Yes

Signature: _____ Date: _____
(Authorized Prescriber's Signature)

◆◆◆ PARENT TO COMPLETE EPI-PEN/INHALER CONTRACT ON BACK OF THIS FORM ◆◆◆

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. I release the Washington County Health Department and Washington County Board of Education and their employees from any claim or liability for administering prescribed medication to this student. **I HAVE READ THE INFORMATION OUTLINED ON THE BACK OF THIS FORM AND ASSUME THE RESPONSIBILITIES AS STATED ON THIS FORM. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.**

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ Emergency phone: _____

MEDICATION GUIDELINES

The following medication guidelines are used in Washington County Public Schools. These guidelines enable the school health staff to provide the best possible service to your child.

1. Whenever possible, medication should be given at home.
2. The first dose of all new medication must be administered at home.
3. In order for medication to be given at school, the medication must be accompanied by a properly completed Physician's Medication Order Form.
4. The school nurse will call the prescriber as allowed by HIPAA if a question arises about child and/or child's medication.
5. Medication must be in the original container from the pharmacy labeled by the pharmacist or prescriber. Non-prescription medication must be in the original sealed container with the label intact. It is also important to make sure the bottle has a current expiration date on it. **Staff may not dispense outdated medication.**
6. An adult must bring the medication to school. No medication will be sent home with a student.
7. All medications are kept in the Health Office. The health staff will make every attempt to notify you in advance when your child's medication is getting low.
8. If your child takes medication in the morning at home, it is important to give it at the same time every day. If your child is coming to school late due to an appointment or a delayed school opening, the morning dose should be given as usual because the school dose will be given at the time ordered. **Any deviation from the scheduled time requires a new order.**
9. Antibiotics which are given three times a day are not usually given at school. Please consult your physician before bringing these medications to school.
10. All medication must be picked up by an adult at the end of the school year. NO medication will be sent home with your child.

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION CONTRACT
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This form must be completed in addition to routine medication administration forms for those students who need to carry medication in order to self administer in an emergency.

1. Student has demonstrated the purpose and the appropriate method and time to administer the inhaler / epi-pen to the nurse.
Please circle one.
2. Student agrees to never share the inhaler / epi-pen with another student.
Please circle one.

For Asthma medication:

- a. Student agrees that after two puffs, if there is not marked improvement, he/she will go to health office.
- b. It is advisable that a spare inhaler be kept in the health office.

For Epi-Pen:

- a. If student self-administers epi-pen, he will immediately have someone notify health office staff.
- b. It is advisable that a spare epi-pen be kept in the health office.

The student may be subject to disciplinary action if he/she does not use the medication in a safe and proper manner.

Student Signature

Date

Nurse Signature

Date

Administrator Signature

Date

I give permission for my child _____ to carry the inhaler/epi-pen as prescribed by the physician. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

Parents' Signature(s)

Date

Parents' Signature(s)

Date