Reading Public Schools MEDICATION ADMINISTRATION ORDERS AND CONSENT FORM

Name: Address: Diagnosis: 1. Medication: Dosage: Date of Order: Date of Order: Date of Order: Date of Order: Date of Order: 3. Medication: Date of Order: Date of Order:	Time of Admii age: Time of Admii age: Time of Admii	nistration: _Frequency: nistration:_ _Frequency:	_Sex: M/F
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To be completed if not in violation of confid	ontiality:		
To be completed if not in violation of confid		a those aiven	a during and
Please list all medications the child is received after school hours	virig, iriciuulii	g illose giver	i during and
after school hours.	offooto:		
Please include adverse reactions and side	епесіѕ:		
Signature of Physician:			
Phone #			
	_		
PARENTAL (CONSENT		
1. I give my permission to have the so	hool nurse ad	Iminister the	medication
ordered above.	star ta calf adı	miniatar mad	ication
2. I give permission for my son/daugl			
(such as inhalers and epi-pens) at school a	ind /or on neid	ı irips wiiri pi	iysician s
signature. (Grades 5-12 only)	roo to oboro i	with appropri	oto oobool
3. I give permission to the school nu			ate school
personnel, information relative to this stude			1
4. I authorize a teacher or chaperon	•	alified by the	school
nurse to administer this/these medications	on field trips.		
Please note: I understand that I may retrie	ve the medica	ation from the	e school at
any time, and that the medicine will be des			
termination of the order or beyond the clos	li Oycu ii il is i	, ,	J
Parent/Guardian (nlease print):	•		
Parent/Guardian (please print):Signature of Parent/Guardian:	e of school.		
Relationship to Student:	e of school.		

Telephone number: _	 Emergency
number:	