



Standard Medication Order Form
For ALL Medications to be Administered During School Hours
Los Medicamentos que se Administrarán Durante el Horario Escolar

Student Name: _____ **DOB:** _____ **Gender:** M / F

Prescription Form to be completed by the ordering Physician/Nurse Practitioner. *El Formulario de Prescripción debe ser completado por el Médico/Enfermera Profesional que realiza el pedido.*

Start Date Order is in effect: _____ **Ending Date:** _____
(All Medication orders need to be renewed each academic year on a separate order form.)

Name of Medication / Nombre del Medicamento: _____

Medical Diagnosis for use of this Medication: _____ **Allergies:** _____

Administration: Route: _____ **Dosage:** _____ **Time:** _____ **or / PRN**

PRN Medication guidelines: Frequency: _____ **(Please circle) May repeat: x 1 or 2**

Specific Indication/Directions for PRN Medications:

Side Effects: _____

If this RX is for an Inhaler or Epi-pen can this student self-administer? Yes / No

Print: _____ **Sign:** _____ **Date Ordered:** _____

Physician/Nurse Practitioner/Physician Assistant Signature

Please provide physician's office stamp in space provided:

I request that my child be assisted in taking the above medication as prescribed by the PCP/NP during school hours by an authorized person or is permitted to self-medicate themselves as prescribed by the health care provider and authorized by me. I give my permission for the nurse to discuss with the prescriber and school staff as necessary information on this form. Solicito que una persona autorizada me ayude a mi hijo a tomar la medicación mencionada anteriormente según lo prescrito por el PCP / NP durante las horas escolares o se me permite auto-med icarse según lo prescrito por el médico y autorizado por mí. Doy mi permiso para que la enfermera discuta con el prescriptor y el personal escolar la información necesaria en este formulario.

Parent/Guardian Signature / Firma del Padre/Tutor

Date / Fecha

Home Phone/Teléfono Residencial: _____ **Cell Phone/Teléfono Celular:** _____

Emergency Phone/Teléfono de Emergencia: _____ **Relation/Relación:** _____

School Nurse Signature: _____ **Date Received:** _____