Resurrection – St. Paul School – Medication Form/Physician Order
(To be completed by Physician/Authorized Health Care Provider)

School Year ______________

I authorize school personnel to administer this medication to my child Parent Signature: __________________________ Date: _______________

Student Name: ____
Date of Birth: ________________ Grade: _______ Gender: M / F
Allergies: ____
Possible Medication Side Effects: ___________________________
____
Special Instructions: _____________________________________
____

Name of Medication: ____
Reason for Medication: ____
Dose: ___________________ Strength: ____________ Route: __________
Time to Give Medication: _______________________________________
Frequency of Medication: _______________________________________
Date Medication Expires: _______________________________________
Order Expires End of School Year or (date): _________________________

_ Student may carry and self administer inhaler or Epipen. Prescriber Initials ___________

Physician/Prescriber Name (please print)	Physician/Prescriber Signature	Date	Phone Number

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																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

Name/Position	Initials	Name/Position	Initials

Codes:

X – School Closed
A – Absent
N – None Available
D/C – Med. Discontinued
FT – Field Trip
ED – Early Dismissal
R – Refused
O – Omitted
H – Dose Held
L/E – Late Arrival / Early Dismissal

Nurse Reviewed:	**Date:**

(KSS 01/07)