RANDOLPH COUNTY SCHOOLS
40 Eleventh Street, Elkins, WV 26241 Phone: 304-636-9150

PHYSICIAN ORDER FORM FOR MEDICATIONS

TO: ______________________ FOR: ______________________ ____________ ______
Physician's Name (Please Print) | Student's Name | Date of Birth | Age

______________________ ______________________ ____________
Physician's Address | School | Grade

______________________ ______________________ ____________
Physician's Telephone | Parent(s)/Guardian's Name(Please Print) | Parent/Guardian Telephone

PARENTS/GUARDIANS ARE ADVISED TO GIVE MEDICATIONS AT HOME ON A SCHEDULE OTHER THAN DURING SCHOOL HOURS IF POSSIBLE.

This form must be filled out at the beginning of each school year for any student who must take daily medication during school hours for an extended period of time (e.g. more than two weeks). This also applies for any PRN medication that must be administered for a life threatening situation. Example: Epi-Pen for severe allergic reaction, glucagon for low blood sugar crisis, inhaler or nebulizer treatments for asthma attack. If any change in medication or dosage takes place, a new form must be completed.

NOTE: Both physician's and parent's signatures are required at the bottom of the form.

Physician Only

Use one form for each medication

NAME OF MEDICATION: ______________________

DOSAGE: ______________________ FREQUENCY: ______________________

EXPECTED TIME OF ADMINISTRATION: ______________________

METHOD OF ADMINISTRATION: ______________________

POSSIBLE SIDE EFFECTS: ______________________

____

ALLERGIES: ______________________

This medication must be given during school hours for the treatment of: ______________________

____

Other Instructions:
May this student self-administer this medication if permitted by county policy? Yes or No (circle one)
May this student carry this medication on his/her person if permitted by county policy? Yes or No (circle one)

Physician's Signature: ______________________ Date: ____________

Parent Permission Statements

I give permission for the school nurse or designee to administer the above medicine to my child at school as prescribed above.

I also give permission for the school nurse to contact the above prescribing physician/health care provider to exchange information regarding my child's health status if necessary.

Parent/Guardian Signature: ______________________ Date: ____________

Please return this form to the school office

2 copies White Copy: Student's File
Yellow Copy: School Nurse

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