Jefferson County School Health Services
MEDICATION ORDER FORM

I. FOR COMPLETION BY PARENT/GUARDIAN

NAME OF STUDENT _____ Date of Birth _____
Last First Middle

NAME OF PARENT/GUARDIAN _____ Phone # _____

NAME OF SCHOOL _____ SCHOOL YEAR _____

TO THE PARENTS: I hereby request that authorized staff of the Jefferson County School System administer prescribed medication as directed by the physician (item II below). I have read the Jefferson County Board of Education guidelines regarding student medication and assume responsibilities as outlined.

Before a school, it's agents, employees or representatives, can administer any medication to your child, you are required to sign this authorization form which signifies your request to have the medication administered, as well as your agreement to relieve the school, its agents, employees, or representatives of any responsibility resulting from the administering of said prescribed medicine as set forth herein.

_____ _____
Parents/Guardian Signature Date

II. FOR COMPLETION BY AUTHORIZED PRESCRIBER (for medication given during school hours.)

DRUGS	DOSAGE (in mgs)	Time to be given

THE MEDICATION IS TO BE ADMINISTERED ONLY UNTIL _____.
DATE

ROUTE OF ADMINISTRATION _____
(if administered by EpiPen, Inhaler, Nebulizer, etc., complete box below)

POSSIBLE SIDE EFFECTS _____

DIAGNOSIS _____

MEDICATION BY EPIPEN, INHALER, NEBULIZER, ETC. _____

TYPE OF DEVICE _____

SPECIFIC DIRECTIONS FOR USE _____

STUDENT MAY CARRY INHALER YES NO

III. PHYSICIAN OR OTHER AUTHORIZED PRESCRIBER SIGNATURE REQUIRED.

_____ _____
PHYSICIAN'S SIGNATURE DATE

_____
PHYSICIAN'S PRINTED NAME

_____
PHYSICIAN'S ADDRESS

_____
PHYSICIAN'S PHONE NUMBER

NKDA: _____
(No known drug allergies)

ALLERGIC TO:

THE SCHOOL NURSE MAY CONTACT YOUR PHYSICIAN AS NEEDED