

# Pierce County Medical Society Physician's Orders for Medication at School

Patient: \_\_\_\_\_

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee if the school nurse is not present. The principal will designate the person responsible to dispense medication on an individual basis.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during school hours?     Yes     No

If yes, please give diagnosis or reason: \_\_\_\_\_  
\_\_\_\_\_

Drugs and dosage form: \_\_\_\_\_

Dose and mode of administration: \_\_\_\_\_

Time(s) to be given:     Lunch     Hour \_\_\_\_\_     PRN

Duration without subsequent order: \_\_\_\_\_ weeks    \_\_\_\_\_ months    \_\_\_\_\_ school year    Other: \_\_\_\_\_

Side effects of drug (if any) to be expected: \_\_\_\_\_

Inhaler to be carried by student:     Yes     No     Not Applicable

Physician Signature: \_\_\_\_\_ Print or stamp name: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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## Parent's Permission

I request that the school nurse, principal or a staff member designated by him/her be permitted to dispense to my child,

(name of child) \_\_\_\_\_ the medication prescribed by

(name of physician) \_\_\_\_\_ for a period from \_\_\_\_\_ to \_\_\_\_\_.

The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions.

This authorization is good for the current school year only.

In case of necessity the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

Date: \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Parent Contact Numbers: Home: \_\_\_\_\_ Other: \_\_\_\_\_ School: \_\_\_\_\_