HCPSS SCHOOL HEALTH SERVICES

Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)

Student Name:_____ Gender: M F Date of Birth:_____ Grade:_____ Date of Order: _____

School: _____ Order Expires End of School Year **or** (date): _____

Reason for Medication:_____ Order valid for current year including summer school (Check if appropriate) ☐

Name of Medication:_____ Dose: _____ Strength:_____

Time to Give Medication:_____ Route:_____ Frequency of Medication: _____ Date Med. Expires:

Possible Side Effects:_____ Allergies:_____

Special Instructions

☐ Student may carry and self administer medication for asthma or other airway constricting conditions MD Initials _____

PRINTED PHYSICIAN/PRESCRIBER NAME AND SIGNATURE	PARENT/GUARDIAN SIGNATURE

Medication Administration Record (For School Use Only)

Nurse Reviewed: **Dates Reviewed:**

	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																															
July																															

Name/Position	Initials	Name/Position	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Nursing assessement has been completed for student self-administration_____

Student may / may not self administer (Circle One) RN Signature Date

CODES: Chart reason (See H.S. Manual)

X: School Closed FT: Field trip
A: Absent R: Refused
N: None Available O: Omitted
NS: No Show to HR H: Dose Held
D/C: Med. Discontinued
L/E Late Arrival/Early Dismissal

HCPSS/DSFCS/OSS/Health Services/Medication Order Form /pat/7/05