

Form

MEDICATION ADMINISTRATION ORDER/PERMISSION FORM

Student's Name _____ Date of
Birth _____

Diagnosis _____
—

Name of
Drug/Medication _____

Dosage to be
given _____

Time to be
given _____

Purpose of
medication _____

Duration of
therapy _____

Anticipated Adverse
Reactions _____

ADMINISTERING MEDICATION (continued)

We give our permission for the above drug/medication to be administered to this student by the school nurse.

Attending Physician's

Signature_____

Date_____

Parent

Signature_____

Date_____

Approved by School Chief Medical Officer Yes _____ No_____

Signature_____

Date_____