MEDICAL FORM 3 MED-3

MEDICATION ORDER 2017-18

Four Rivers Charter Public School

(TO BE COMPLETED BY A LICENSED PRESCRIBER)

Name of Student_____ Date of Birth_____ Grade_____

Address_____

_____

Name of Licensed Prescriber_____

Business Telephone Number _____

Emergency Telephone Number_____

Medication_____

Route of Administration_____ Dosage _____

Frequency_____ Time(s) of administration_____

(Please note: *Whenever possible, medication should be scheduled at times other than school hours*)

Permission to self-administer/carry on person: YES____ NO____

Specific directions or information for administration_____

Date of Order: _____ Discontinuation Date: _____

Diagnosis *(If not in violation of confidentiality)* _____

Any other medical condition(s) *(If not in violation of confidentiality)* _____

Optional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed:

   _____

   _____

2. Other medication being taken by the student:

   _____

   _____

3. The date of the next scheduled visit or when advised to return to Prescriber: _____

_____

Signature of Licensed Prescriber *Date*

I consent to have the School Nurse, or school personnel designated by the School Nurse, administer the above medication prescribed by _____ to _____.

Licensed Prescriber *Student Name*

_____ _____

Parent/Guardian Signature *Date*