

MEDICAL FORM 3
MEDICATION ORDER 2016-17

MED-3

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