THORNTON FRACTIONAL TOWNSHIP HIGH SCHOOL DISTRICT 215

Medication Order Form

- All medications must be presented to the School Nurse along with a written Physician's Medication Order and Parental/Guardian Permission statement.
- This form should be used to record the Physician's Order and Parental/Guardian statement.
- All medications **must** be in their original medication container with the student's name appearing on the label.
- All physician's orders and parental permission statements **must** be renewed yearly.

Student's Name: _____

I.D. Number: _____ Date of Birth: _____

Health Concerns: _____

Allergies: _____

Physician's Medication Order

Medication Name: _____

Frequency or Time of Administration: _____ Dosage: _____

Route of Administration: _____

Possible Side Effects: _____

Date to be discontinued: _____ **NOTE:** A new physician's order and parental permission must accompany all medication changes.

*If medication is a multi-dose inhaler or similar medication, should medication be carried and self administered by student? _____ Yes _____ No

Special Instructions: _____

Physician's Name (Please print): _____

Physician's Signature: _____ Order Date: _____

Address: _____ Phone Number: _____

Parent/Guardian's Permission for Student's Medication at School

I, _____, the parent/guardian of _____ give my permission for the above medication to be administered as prescribed.

Parent/Guardian's Signature: _____

Date: _____ Phone Number: (home)_____ (work)_____

THORNTON FRACTIONAL TOWNSHIP HIGH SCHOOL DISTRICT 215

Non-Prescription Medication Order Form

- All non-prescription medications must be presented to the School Nurse along with a written Non-Prescription Medication Order and Parental/Guardian Permission statement.
- This form should be used to record the non-prescription information and Parental/Guardian statement.
- All non-prescription medications **must** be in their original medication container with the student's name appearing on the label.
- The non-prescription medication dosage **must not** exceed the recommended dosage unless specifically ordered by a licensed physician.
- All physician's orders and parental permission statements **must** be renewed yearly.

Student's Name: _____

I.D. Number: _____ Date of Birth: _____

Health Concerns: _____

Allergies: _____

_____

_____

Non-Prescription Medication

Medication(s) Name: _____

Dosage: _____ Time of Dosage: _____ Route: (circle) Topical Oral

Date to be discontinued: _____

Special Instructions: _____

Note: A **new** Non-Prescription Medication Order Form must accompany all non-prescription medication changes.

Parent/Guardian's Permission for Student's Medication at School

I, _____, the parent/guardian of _____

give my permission for the above non-prescription medication to be administered as prescribed.

Parent/Guardian's Signature: _____

Date: _____ Phone Number: (home) _____ (work) _____