



**MEDICATION ORDER**

**INSTRUCTIONS**

This form must be completed in order for the student to receive medication(s) at school; this includes both **prescription and non-prescription** medications (including lotion, lip balm, deodorant, diaper rash cream, toothpaste, etc.). The school is not allowed to make any changes to the health care provider instructions written on this form. Any changes concerning the medication type, dosage or procedure will require a new form to be completed by the health care provider and be on file at the school the student is attending. **The school nurse or a trained staff member** will give the medication. The order will be in effect for no longer than **one school year**.

**STUDENT INFORMATION**

STUDENT NAME	DATE OF BIRTH	SCHOOL
NAME OF PARENT/LEGAL GUARDIAN		
ALLERGIES		

**MEDICATION**

NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
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INSTRUCTIONS				
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INSTRUCTIONS				
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INSTRUCTIONS				
NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
HEALTH CARE PROVIDER'S NAME	HEALTH CARE PROVIDER'S SIGNATURE (M.D., D.O. OR NURSE PRACTITIONER ONLY)			DATE
ADDRESS				PHONE NUMBER

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