NORTHWOOD SCHOOL DISTRICT
ORDER FOR MEDICATION ADMINISTRATION AT SCHOOL
(Please print or type)

Date order effective to:_____

School:_____

Name of student:_____

Physician/Provider:_____

Diagnosis:_____

_____.

Medication/dose/frequency/duration:_____

Medication/dose/frequency/duration:_____

Check one: Short term [ ] Long term [ ]

PRN (as situation demands) Medication:_____

Medication/dose/frequency/duration:_____

If PRN medication, state condition which medication is to be given:_____

_____.

NOTE

My signature on this document attests to my willingness and intent to direct and supervise the administration of the medication by non medically trained designees appointed by the school administration for that purpose. I will accept direct communications from them regarding the administration of the medication. This consent is valid for the current school year.

_____ _____
Physician signature Date

My signature on this document confirms these medications have been prescribed for my child. I agree to this plan and will supply medications to the school in the pharmacy labeled bottle.

_____ _____
Parent signature Date