Wirt County Schools Health Services
P.O. Box 699
Elizabeth, WV 26143

Phone: 304-275-0361
Fax: 304-275-4257

MEDICATION ORDER FORM

CONFIDENTIAL

Student Name _____
Last First Middle

Birth Date _____ Grade _____ Age _____

Parent/Guardian Name (PRINT) _____

Parent/Guardian Phone (Home) _____ (Work) _____ (Cell) _____

This form is to be completed by a licensed prescriber. It is valid for the current school year for prescribed and non-prescribed (over-the-counter) medication. If any change in medication, dosage, time, or route is needed, a new Medication Order Form must be received before medication can be administered by school personnel.

PRESCRIBED and NON-PRESCRIBED (Over-the-Counter) MEDICATION

USE ONE FORM FOR EACH MEDICATION

Medication _____ Diagnosis/ICD-9 Code _____

Dose _____ Time of Administration _____

Method of Administration _____

Intended effect of medication _____

Name and Title of Licensed Prescriber (PRINT) _____

Address _____

_____

Phone _____ Fax _____

Signature of Licensed Prescriber _____ Date _____

Parent/Guardian Authorization

Total dosage of this medication to be given in 24 hour period _____

This medication at this total daily dosage has been given at home, and my child did not demonstrate any adverse effects.

Other medications taken by student _____

☐ Check this box and use back to provide additional information.

Medication Allergies _____

The licensed prescriber has discussed with me the risks and benefits of this medication at this dosage and course of treatment.

I understand the licensed prescriber may be contacted concerning medication order for reasons including, but not limited to, clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.

I understand that, with due notification of licensed prescriber and parent/guardian, the school nurse/Wirt County Schools may discontinue medication administration if student's health appears to be at risk.

I understand that medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.

I understand a photograph of my child may be taken to assist in the correct administration of my child's medication.

I hereby give my permission for my child to receive medication at school as ordered by my child's licensed prescriber.

Parent/Guardian Signature _____ Date _____