St. Croix Central School District

Physician Order for Administration of Prescription Medication

Name of Student:_____ DOB:_____

Grade:_____ Teacher:_____

Allergies:_____

Prescription Information and Physician Signature

Medication:_____ Dose:_____

Frequency:_____ Time:_____

Diagnosis:_____ Route: _____

Physician Signature:_____ Date:_____

Physician Name(please print):_____ Phone:_____ Fax:_____

Parent Signature and Information

1. I request this medication be given as prescribed by the physician. I understand I must provide this medication in the original container (bottle, injection or inhaler) labeled by the pharmacy.
2. I understand that written instructions must be provided by the physician if there is a change in medication, including but not limited to medication type, dosage, or timing.
3. I will notify the school when the medication is discontinued and I will pick up the medication.
4. I will pick up the medication at the end of the school year. If my child is attending summer school, I will pick up the medication by the last day of summer school.
5. **I understand that medication orders must be renewed at the start of each school year.**
6. **I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I give permission to contact the prescribing physician.**
7. I understand that when the student is on a field trip the above medication will be given to the appropriate teacher to supervise and administer.

Parent/Guardian signature:_____ Date:_____

Print Name:_____ Phone:_____

How would you like to be contacted when refills are needed? □ by phone □ e-mail _____

□ other_____