Jefferson County School Health Services
MEDICATION ORDER FORM

I. For Completion by Parent/Guardian

Name of Student______________________________Date of Birth_________
Last                                           First                        M.I.
Name of Parent/Guardian_________________________Ph.#_____________
School:________________________________________School Year____________

To Parent/Guardian: Before a school, its agents, employees, or representatives can administer any medications to your child, you are required to sign this authorization form which signifies your request to have the medication administered, as well as your agreement to relieve the school, its agents, employees, or representatives of any responsibility resulting from the administering of said prescribed medication as set forth herein.
I hereby request that the authorized staff of Jefferson County Public School System administer prescribed medications as directed by the physician (item II below). I have read the Jefferson County Board of Education guidelines regarding student medication (SPO 12.1) and assume responsibilities as outlined.

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Parent/Guardian Signature                                                                       Date

II. For Completion by Authorized Prescriber (For medication given during school hours)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage (in mgs)</th>
<th>Time to be Given</th>
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<tbody>
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</tbody>
</table>

This medication is to be administered only until ____________________________
Route of administration ____________________________
(If administered by Epi-Pen, Inhaler, Nebulizer, etc., complete box below)
Possible Side Effects ______________________________________________________
Diagnosis_________________________________________________________________

<table>
<thead>
<tr>
<th>Medication Given by Epi-Pen, Inhaler, Nebulizer, Etc.</th>
<th>Drug Allergies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Device</td>
<td>Yes</td>
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<tr>
<td>Specific Directions</td>
<td>No</td>
</tr>
</tbody>
</table>

May Student Carry Inhaler?   Yes             No
(Circle One)

Drug Allergies?             Yes            No
If yes, allergic to?

III. PHYSICIAN OR OTHER AUTHORIZED PRESCRIBER (Signature Required)

________________________________________  _______________________
Physician/ Other Authorized Signature                                                    Date

________________________________________
Physician/Other Authorized Printed Name

________________________________________
Practice Address     and     Phone Numbers

The School Nurse May Contact Your Physician As Needed