Jefferson County School Health Services May Fax to: 304-728-9521

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, it's 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, it's 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.

X_____ _____
Parent/Guardian Signature Date

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

Medication	Dosage (in mgs)	Time to be Given

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_____

Medication Given by Epi-Pen, Inhaler, Nebulizer, Etc.
Type of Device_____
Specific Directions_____

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