MOTHER OF GOD SCHOOL

Medication Form – Physician's Order

Medication Authorization

While most medications will be given at home, there are circumstances in which medications should be kept on-site for administration as needed at school. If your child will need medication administered at school (other than an epi pen or inhaler for which there are specific forms provided), please complete the following Medication Authorization Form.

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To be completed by the Physician/Authorized Health Care Providor

School: _____ Grade: _____ Date of Order: _____

Order Expires at End of School Year (Y/N) or Date: _____ Order Valid for Current Year/Summer (Check if Yes) €

Student Name: _____ DOB: _____ Sex: male / female

Name of Medication: _____ Dose: _____ Route: _____ Time to Administer:_____

Reason for Medication: _____ Frequency of Medication (if PRN): _____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: € Yes € No

Parent/Guardian Name: _____ **Physician Name:** _____ **Phone:** _____

Parent/Guardian Phone:_____ **Physician Address:** _____

Parent/Guardian Signature: _____ **Prescriber Signature:** _____

Medication Administration Record (For School Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															
Jul																															

Name/Postion: Initials: Name/Position: Initials:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

RN Signature: _____ Date: _____

CODES: Chart Reasong (See H.S. Manual)

X: School Closed
FT: Field Trip
A: Absent
R: Refused
N: None Available
O: Omitted
NS: No Show to HR
H: Dose Held
D/C: Med Discont.
L/E: Late Arr./Early Dis.

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Student Name: _____

Date	Time	Student Complaint	RN Consulted √	Medication Administered as Ordered √	Student Outcome	Staff Initials	Parent Notified √
Comments:							