CATE SCHOOL

Physician Order for Medication Administration

Parent/Guardian and Physician Signature Required

_____

Student Name Date of Birth

Current medication your child takes including drug name, dosage, route, time(s) of day, required daily or as needed (PRN), if taken with food and any specific instructions. If more than 3 medications are required, please photocopy and use an additional sheet.

Medication 1:_____May substitute generic: □ Yes □ No Taken with food: □ Yes □ No

Prescribed Dosage:_____Route: _____Time of administration:_____ Required daily or prn: □ Daily □ PRN

Instructions:_____Omit for weekends or non-class days: □ Yes □ No

Titration (if required):_____

Medication 2:_____May substitute generic: □ Yes □ No Taken with food: □ Yes □ No

Prescribed Dosage:_____Route: _____Time of administration:_____ Required daily or prn: □ Daily □ PRN

Instructions:_____Omit for weekends or non-class days: □ Yes □ No

Titration (if required):_____

Medication 3:_____May substitute generic: □ Yes □ No Taken with food: □ Yes □ No

Prescribed Dosage:_____Route: _____Time of administration:_____ Required daily or prn: □ Daily □ PRN

Instructions:_____Omit for weekends or non-class days: □ Yes □ No

Titration (if required):_____

I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. Should a change in any of the information occur, I understand that a revised written physician's statement and parent authorization must be submitted as soon as possible. **I hereby authorize an exchange of information between the Health Center staff and the physician/HCP listed below regarding the prescribed medication(s). At school/school functions, I request that medication(s) be administered to my child by trained school staff in accordance with the physician's/HCP written instructions above.**

_____

Parent/Guardian Printed Name Parent/Guardian Signature Date

_____

Physician Name Phone Number

_____

Physician Signature/DEA Number Date