



**Medical Order Form**  
**2023 - 2024**

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_

Licensed Medical Provider \_\_\_\_\_ Title \_\_\_\_\_

Phone \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Medication \_\_\_\_\_ Diagnosis \_\_\_\_\_

Route of administration \_\_\_\_\_

Dosage/Frequency \_\_\_\_\_

Time(s) of administration \_\_\_\_\_

Specific directions for administration \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Special side effects, contraindications or possible adverse reactions or reactions if medication is not given: \_\_\_\_\_

\_\_\_\_\_

Storage: \_\_\_\_\_

Consent for self-administration by student (with approval of parent/guardian and school nurse)

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature of Medical Provider

\_\_\_\_\_  
Date

I request that the medication, named above, be given to my child. The medical provider explained, to me, the medication, its purpose and possible complications.

\_\_\_\_\_  
Parent/Legal Guardian's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian's signature

\_\_\_\_\_  
Date