MORRISON SCHOOL
INTEGRITY • EXCELLENCE • STRENGTH

Medical Order Form
2024 - 2025

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

Morrison School Fax #276-285-3828