WEST VALLEY SCHOOL DISTRICT NO. 363
2009 TO 2010 SCHOOL YEAR

MEDICATION ORDER FORM
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name:____________________________ Birth Date: ____________________
School Name: _____________________________ Grade: __________________

This portion to be completed by the licensed health care professional prescribing within the scope of their licensed prescriptive authority.

Name of Medication Dosage Method of Administration Time of Administration
____
____

Diagnosis or reason for medication:
____
____

If given PRN, specify the length of time between doses: ________________________________
Inhalers:____
Possible side effects of medication: ____
Emergency procedures in case of serious side effects: ________________________________

Indicate if student may carry on his/her person:
Student is capable of self-administration of medication: Yes______ No _______
Student may carry on his/her person: Yes ______ No________

I request and authorize the above named student be administered the above identified oral medication in accordance with the instructions indicated above from _______ (date) to _________ (date) (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_________________________ ____________________________________
Date of signature Licensed Health Professional

___________________ ________________ _______________________________
Phone number Fax number Name (Print or Type)

**Please note if samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

This portion to be completed by the parent or legal guardian.

I request/authorize the school to administer medication to the above identified student in accordance with the LHP's instructions for the period from _______ (date) to _______ (date) (not to exceed this school year).

Permission to carry medication or inhaler (if LHP agrees) Yes __________ No ___________
Permission to self administer medication (if LHP agrees) Yes __________ No ___________

_______________________ __________________________________
Date of signature Parent of Legal Guardian

_____________________ __________________ _________________
Phone numbers: home cell work

5/09