obbs Municipal Schools

Physician Order and Medication Authorization Form

Medication will be administered in the school **ONLY** when it is necessary for a student to remain in school. Medication should be sent to the school with or for a student **ONLY WHEN IT IS AN ABSOLUTE NECESSITY.**

The purpose of this policy is to ensure that students do receive necessary medication according to their physician's orders and to ensure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to supervise your child with self-administration of medication when the school nurse is not available.

Should you be asked to complete one of these forms, please read the form thoroughly and respond to ALL items. Contact the school nurse if you have any questions. THANK YOU

THIS form is for **one** medication/authorization AND is only valid for the current school year**.**
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Student's Name ____ Date: ________________

School: ___________________________________ Teacher: ______________________________

Allergies: ____

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis) ____________________________________ and have determined she/he requires medication during school hours.
2. Name of medication ____________________________________ Dosage ________________
3. Time of administration ____________________ Duration of Administration______________
4. Special instructions regarding this medication _______________________________________
5. Symptoms of Adverse Reactions ____

For use of inhalers: I believe this student is able and needs to carry and administer her/his inhaler for severe asthma. ***Please check*** ____ YES ____ NO
The student has been instructed in the care/use of the inhaler. ***Please check*** _____YES _____ NO

Physician's Signature ___________________________________ Date ____________________

Printed Name ____ Phone ___________________

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PARENT/GUARDIAN STATEMENT:

I/We, the parent(s) of ____
(Student's Name)
hereby request that this medication be given to my/our child according to the physician's instructions.

I/We agree to furnish the necessary medication in a pharmacy/original labeled container, provide replacement medication as necessary, and to provide a new physician's statement if there is **ANY** change in the medication, dosage, administration time, administration route, or special instructions regarding the medication. I/WE understand that other designated personnel (other than the school nurse) may supervise the child with self-administration of medication.

Parent(s)/Guardian's Signature: ____ Date _________

Reviewed/Revised: June, 2006