KING PHILIP REGIONAL SCHOOL DISTRICT

MEDICATION ORDER

To be completed by a licensed medical provider and parent/guardian
before any medication can be dispensed in school.

Student Name_____ D.O.B._____ Grade_____

Physician Medication Order:

Medication_____ Dosage_____ Route_____

Frequency_____ Time(s) to be given at school _____

Specific Instructions _____

Consent for self-administration of ____ insulin ____ inhaler ____ Epipen ____ (provided that

the school nurse determines it is safe and appropriate: Yes _____ No _____

Date of Order _____Discontinuation Date _____

Diagnosis *_____ Drug/Food Allergies _____

Signature of licensed provider _____ Date _____

Parent/Guardian Consent:

Name of Parent/Guardian _____ Relationship to student _____

Please list any additional medications currently taken by student _____

Consent for self-administration of ____ insulin ____ inhaler ____ Epipen if the nurse

determines that it is safe and appropriate: Yes ____ No ____

I, the undersigned parent or guardian, give permission to the school nurse (or school personnel designated by the school nurse) to administer the above medication to my child or to supervise my child in taking the above medication if approved to do so by the school nurse. I authorize the school nurse to share information about such medication administration, as the school nurse deems necessary, for the health and safety of my child. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up at the end of the school year.

Signature of Parent/Guardian _____Date_____

Telephone (home) _____ (cell) _____ (work) _____

Please read the KPSD medication policies on the back of this form.