PRESCRIPTION MEDICATION ORDER
(one form per medication)

Student _____ Date of Birth_____ Grade _____

To be completed by physician or authorized prescriber:

Name of medication _____
Reason for medication: _____

Form of medication/treatment:

____Tablet/capsule ____ Liquid Inhaler_____ Injection____ Nebulizer___ Other____

Instructions (schedule and dosage to be given at school:

_____

Start: date form received other date: _____

Stop: end of school year other date/duration: _____
For epidsodic/emergency event only

Restrictions and important side effects: None anticipated

Yes, Please describe: _____
_____

Special storage requirements: None Refrigerate Other

The student is both capable and responsible for self-administering this medication:

☐ Yes ☐ No ☐ N/A

Please indicate if you have provided additional information: ☐ On the back side of this form ☐ As an attachment

Date: _____ Licensed Prescriber's Signature _____

Physician's Name:_____
Address: _____
Phone Number: _____

To the school: Please report concerns about medication or condition to the above physician.

TO BE COMPLETED BY PARENT/GUARDIAN:
I have read and understand the Pingree School medication policy. I give permission for

_____ to receive the above medication at Pingree School according to school policy.
Name of Child
Date: _____ Signature: _____ Relationship:_____