False River Academy
Physician Order

This form enables the Principal or his/her designee to dispense medication.

Student:_____ DOB _____

Medication Name:_____

Dose/Route _____

Time of administration: _____

Diagnosis: _____

Potential Adverse Effects: _____

Is it necessary that student take medication on the Field Trip: ____Yes _____ No

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To be completed by MD- Use this space ONLY for students who will self administer their asthma inhaler, epinephrine, or insulin:

Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school? _____Yes _____ No

Student may carry necessary item on his/her person. _____ Yes_____ No

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Additional Comments:

_____

_____

My signature enables the parent to give the Principal, or his/her designee, authority to dispense and observe the partaking of prescribed medication.

_____ _____

Physician's Name (Printed) Physician's Signature/Date

Request for School Personnel to Administer Medication

(Please complete all information on this form and return it to the school office.)

Student's Name _____Grade _____

Medication to be administered _____

Dosage_____

Purpose of Medication _____

_____

Anticipated number of days medication needs to be given during school hours:

_____

Possible side effects: _____

My signature authorizes the school secretary, principal, or designee to administer the medication as stated on this form, to my child, _____ and that any side effects from the medication are not the school's responsibility. I also release the school from any liability for any reasons associated with administering medication.

I am aware that False River Academy does not have a school nurse on staff, and my signature further indicates my acknowledgement of this information.

_____ _____

Parent/Legal Guardian Signature Date