

SANDY SPRING FRIENDS SCHOOL MEDICATION ORDER FORM 2008-2009

(top portion to be completed by a physician, nurse practitioner or dentist)-one sheet per medication

Student Name: _____ DOB _____ Grade _____ Reason for Medication _____

Name of Medication: _____ Dose _____ Route: _____ Time _____ Effective Dates: _____

Checking this box indicates that the medication is an epi-pen or inhaler that the student can carry and self-administer

Possible Adverse Effects _____

Any Drug Interactions: _____

Additional Instructions: _____ Student Allergies: _____

Physician/Prescriber Signature: _____ **Date:** _____ **Physician Phone #** _____

Printed Name of Physician _____

*** I release the school and its personnel of any liability related to the administration of the above listed medication. I give permission to the school personnel to communicate directly with the prescribing physician. **(PARENT/GUARDIAN SIGNATURE)** _____ **Date** _____

Please note medication must be in the original container and clearly marked for the student. Medication must be brought to the school by the parent or guardian. Unused or unclaimed medication will be destroyed at the end of the school year.

FOR SCHOOL USE ONLY

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Sept																																
Oct																																
Nov																																
Dec																																
Jan																																
Feb																																
Mar																																
Apr																																
May																																
Jun																																

Name/Position

Initials

Codes (use for unusual situations)

W – Weekend or holiday

F – Med given on field trip

H-medication held

A – Absent

ED – Early dismissal

S- self administer

R – Refused

O – Omitted

N – None available

D/C – Discontinued

**Please document any communication with the RN or parents on the back of this form.*