MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year 2024-2025

Student Last Name First Name Middle | **Date of birth** ___/___/_____ (MM DD YYYY) | ☐ Male ☐ Female

School | | | **Grade** |

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis: ____________________ ICD-10 Code: ☐ _ _ _ . _ _ _

Medication: ______________________
Generic and/or Brand Name

Preparation/Concentration: ______________________

Dose: ____________________ Route: ______________

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis: ____________________ ICD-10 Code: ☐ _ _ _ . _ _ _

Medication: ______________________
Generic and/or Brand Name

Preparation/Concentration: ______________________

Dose: ____________________ Route: ______________

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis: ____________________ ICD-10 Code: ☐ _ _ _ . _ _ _

Medication: ______________________
Generic and/or Brand Name

Preparation/Concentration: ______________________

Dose: ____________________ Route: ______________

Student Skill Level *(Select the most appropriate option):*

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision

In School Instructions

☐ Standing daily dose: at _ _: _ _ am / pm and _ _: _ _ AM / PM

AND/OR

☐ PRN

____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

Health Care Practitioner (Please Print) LAST NAME | FIRST NAME | Signature

Address | Tel. No. (_ _ _)_ _ _- _ _ _ _ | Fax. No (_ _ _)_ _ _- _ _ _ _

E-mail address | Cell phone (_ _ _)_ _ _- _ _ _ _

NYS License No **(Required)** _ _ - _ _ _ _ _ _ _ _ | NPI No. _ _ _ _ _ _ _ _ _ _ | Date ___/___/_____

PARENTS MUST SIGN PAGE 2 ➔

MEDICATION ADMINISTRATION FORM page 2
THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS
PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2024-2025

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
  - I must give the school nurse my child's medicine.
  - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - Prescription medicine must have the original pharmacy label on the box or bottle.
  - No student is allowed to carry or give him or herself controlled substances.
  - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
  - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___/___/______
Parent/Guardian Print Name:	Signature:
Date Signed ___/___/______	Cell Phone:
Other Phone:	Email: