MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year 2025-2026

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 2025-2026

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: