

MEDICATION ADMINISTRATION FORM
THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS
 Provider Medication Order Form | Office of School Health | School Year 2019-2020

Student Last Name	First Name	Middle	Date of birth ___/___/___ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
School			Grade	

HEALTH CARE PRACTITIONERS COMPLETE BELOW

<p>1. Diagnosis: _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p>Medication: _____ Generic and/or Brand Name</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p>Student Skill Level (Select the most appropriate option): <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision</p>	<p>In School Instructions</p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM AND/OR</p> <p><input type="checkbox"/> PRN _____ specify signs, symptoms, or situations</p> <p><input type="checkbox"/> Time interval: ___ minutes or ___ hours as needed. <input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
<p>2. Diagnosis: _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p>Medication: _____ Generic and/or Brand Name</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p>Student Skill Level (Select the most appropriate option): <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision</p>	<p>In School Instructions</p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM AND/OR</p> <p><input type="checkbox"/> PRN _____ specify signs, symptoms, or situations</p> <p><input type="checkbox"/> Time interval: ___ minutes or ___ hours as needed. <input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
<p>3. Diagnosis: _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p>Medication: _____ Generic and/or Brand Name</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p>Student Skill Level (Select the most appropriate option): <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision</p>	<p>In School Instructions</p> <p><input type="checkbox"/> Standing daily dose: at ___:___ am / pm and ___:___ AM / PM AND/OR</p> <p><input type="checkbox"/> PRN _____ specify signs, symptoms, or situations</p> <p><input type="checkbox"/> Time interval: ___ minutes or ___ hours as needed. <input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>

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 ___/___/___	

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THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS
PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2019-2020

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:
 - o I must give the school nurse my child's medicine.
 - o 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.
 - o No student is allowed to carry or give him or herself controlled substances.
 - o 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.
 - o 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: