



## Physician Medication Order Form

Written orders must be provided from a physician detailing the name of the drug, date of the order, diagnosis, dosage, route, time and specific duration for the order. Signature of the parent or guardian is required requesting that Highland School comply with the physician's order. Prescription medications must be brought to school by the Parent or Guardian in the original container, appropriately labeled by the PHARMACY OR PHYSICIAN.

PLEASE COMPLETE AND SIGN. PLEASE FAX INFORMATION TO: NURSE'S OFFICE - 540-347-5860

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

MEDICATION \_\_\_\_\_ Date of Order \_\_\_\_\_

Diagnosis \_\_\_\_\_ Dosage \_\_\_\_\_

Route \_\_\_\_\_ Time \_\_\_\_\_ Specific Duration of Order \_\_\_\_\_

MEDICATION \_\_\_\_\_ Date of Order \_\_\_\_\_

Diagnosis \_\_\_\_\_ Dosage \_\_\_\_\_

Route \_\_\_\_\_ Time \_\_\_\_\_ Specific Duration of Order \_\_\_\_\_

Student has shown me or my staff adequate knowledge of use of inhaler/ Epipen/ bloodsugar kit and I would recommend that this student keep this medication with him/her at all times.

YES \_\_\_\_\_ NO \_\_\_\_\_

Physician Name (printed) \_\_\_\_\_

Physician's Signature (required) \_\_\_\_\_

Date \_\_\_\_\_ Telephone \_\_\_\_\_

I request that the school administer the above medications as ordered by the physician. If my child is allowed to keep an inhalor/epipen, on his/her person, I will not hold the school responsible for any mishap involved with the inhaler on his/her person.

Parent/Guardian Name (printed) \_\_\_\_\_

Parent/Guardian Signature (required) \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_