School District of Somerset

Physician Order for Administration of Prescription Medication

Name of Student:_____ Grade:_____

Date of Birth:_____ Allergies:_____

To Be Completed by a Physician/Prescriber

Name of Medication:_____ Dose:_____

Form of Medication:
❏ Tablet/capsule ❏ Liquid ❏ Injection ❏ Topical ❏ Inhaler ❏ Nebulizer ❏ Drops

Time to be given:_____

Illness/Condition requiring medication:_____

Are there any Special Instructions: ❏Yes ❏No If yes, please explain:_____
_____

The above student understands the correct use, dose and time to take medication: ❏ Yes ❏ No

I give the above student permission to self-carry and administer medication:❏ Yes ❏ No

Signature of Physician: _____ Date:_____

Printed Name:_____ Telephone:_____ Fax:_____

To Be Completed by Parent/Guardian

1. I give permission for my child to receive the above medication as directed and for school personnel to contact the physician/prescriber directly if there are any questions related to the medication treatment
2. I understand I must provide the medication in the original container labeled by the pharmacy (no baggies)
3. I will notify the school of any change in the medication or physician's order immediately (dosage, frequency, duration or discontinuation). I understand that if there is a medication/dosage change during the school year a new written prescriber authorization is required
4. I will pick up the medication at the end of the school year. If my child is attending summer school, I will pick up the medication by the last day of summer school or request that it be sent home with the student
5. I understand that medication orders need to be renewed each school year
6. I understand that when my child is on a field trip, the above medication will be given to the appropriate teacher to supervise and administer

Parent/Guardian Signature:_____ Date:_____

Printed Name:_____ Phone:_____

How would you like to be contacted when refills are needed:❏Phone ❏Email ❏Other:_____