Al-Huda School
PHYSICIAN MEDICATION ORDER FORM

This order is valid only for school year (current) _____including the summer session.

School's Name: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- *Prescription medication must be in a container labeled by the pharmacist or prescriber.*
- *Non-prescription medication must be in the original container with the label intact.*
- *An adult must bring the medication to the school.*
- *The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.*

Prescriber's Authorization

This section must be completed by a liscensed physician, alicensed dentist ro any advance practice nurse.

Name of Student: _____ Date of Birth: _____ Grade:_____

Condition for which medication is being administered: _____

Medication Name: _____ Dose:_____

Route:_____ Time/frequency of administration: _____

If PRN, frequency:_____ If PRN, for what symptoms:_____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title:	
Telephone #:	
Fax:	
Address:	
Prescriber's Signature: _____ Date:_____ *(original signature or signature stamp ONLY)*	

(Use for prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____for the above medication on (Date):_____.

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date:_____

Home Phone #:_____Cell Phone #:_____Work Phone #:_____

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