

# Provider Orders for Medication at School Form - Supplemental

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

## Health Care Provider Orders for Medication at School

### Important notice to provider:

Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name

2) Symptoms for medication use

3) Dose

4) Frequency & Length of time between doses

5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: \_\_\_\_\_ AND End date: \_\_\_\_\_

Health Care Provider's Signature

Date

Print name

Phone #

Fax #

Parent/Guardian Signature

Date

Interpreter Signature

Date

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant

Date

ITE/Teacher Date

ITP/Assistant Date

FA/FE/FSF/HV Date

Dir/C Coor Date