TROY SCHOOL DISTRICT #287

PHYSICIAN'S MEDICATION ORDERS FOR DISPENSING OF MEDICATION IN THE SCHOOL

It is the policy of Troy School District 287 to maintain signed orders for each prescription medication the school personnel are asked to dispense to students during school hours. The following are criteria for renewal of this form:

1.) New school year
2.) Change in medication, dosage and /or time to be administered
3.) Any changes in the medication schedule, i.e. the medication has been discontinued temporarily and then restarted.

The physician's or authorized prescriber's orders must be written and signed on this form or attached to the form. **The School District will not recognize orders written by parents/guardians.** Copies are not valid for additional prescriptions. The parent/guardian may not fill in the physician's name in the signature block.

School: ________________________________ Date form received by the school: ___/____/____

Student: ________________________________ DOB: ___/___/___ Grade: _________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication: ________________________________

Name of medication: ________________________________

Form of medication/treatment & **amount** received:

___tablet ___liquid ___Inhaler ___Injection ___Nebulizer ___Other ______________________

This student may carry this medication (option only available for inhalers and topical)___No ___Yes

Physicians Initials___________

Please keep in mind inhalers are readily accessible when stored in the office. Many students who carry respiratory inhalers do no report this and may present an emergent situation. If the student is permitted to carry this medication, this form must still be completed and turned into the office at the school so that we may be aware of the medication availability.

Instructions (schedule and dose to be given at school): ________________________________

Start: _________ **Date form received** **Other date:** ______________________

Stop: _________ **End of school year** **Other date/duration:** ______________________

Restrictions and/or important side effects: ___None anticipated ___Yes. Please describe_____________________

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Special storage requirements: ___None ___Refrigerate ___Other:________________________________

Date: _______ **Physician's Signature:** ________________________________

Physician's Name:	Phone Number:
Address:	

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child)__________________________to receive the above medication at school according to standard school policy. Additionally, I give permission for the school to contact the prescribing physicians and receive information as needed in implement the dispensing. District policy requires all medication to be brought to school in its original container. The school needs to have the doctor's orders affixed to the medication. (Label with patient's full name and dosage.) I release the school and its personnel from any and all liability should adverse reaction occur as a result of medication.

Date:______________ Signature:____________________________________ Relationship to student:_______________