Written Order for Medication

HMP 2000 ©

Physician/Practitioner

In order to protect the health and welfare of the students and school staff alike, Indiana laws requires that parents consent, in writing to the administration of medication. In order for the school nurse, volunteer school nurse, or a staff member to administer medication to your student the form below must be read and signed.

1. The school **must have on record a written order from the prescribing physician/practitioner and written consent from the parent/guardian for prescription medication**. There must be a written request from the parent/guardian for Over the Counter (OTC) medications before they will be administered to a student at school.
2. Medications prescribed and/or OTC meds should be kept in the original container with the pharmacy or brand label affixed. The label must include the following:
   - Student's Name
   - Name of Medication
   - Dosage of Medication
   - Prescribing Physician/Practitioner (if applicable)
3. Medication brought to the school must be checked in at the office and kept in a locked cabinet.
4. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication
5. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
6. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff can not take a physician order over the phone.
7. Over-the-counter medication will not be administered in any manner inconsistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

I have read and understand the above policy.

Please administer to my patient _____, the prescribed/over-the-counter medication(s) as described below:

Medication	**Dosage** **(Mg and # of tabs)**	**Time**	**Precautions/side effects**
1.			
2.			
3.			
4.			

- Period of time medication is to be continued: _____
- Reason for medication: _____

Physician/Practitioner Signature _____ Date _____

Please Print/Stamp Here _____

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