



ALL SAINTS ACADEMY

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Part A: To be filled out by Licensed Prescriber:

Name of Student: _____ Date of Birth: _____

Office Telephone Number: _____

Name of Medication: _____

Route: _____ Dose: _____

Frequency: _____ Time: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis: _____

Any other medical conditions: _____

Additional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____

2. Other medication being taken by the student: _____

Signature of Licensed Prescriber: _____

Part B: To be filled out by Parent/Guardian:

1. I give special permission for the school nurse to administer medication as per this medication order.
YES _____ NO _____
2. I give permission for the school nurse to instruct a trained, responsible adult in administering the above mentioned medication to my child.
YES _____ NO _____

Parent/Guardian Signature: _____