

Physician's Orders for Medication In School

*To Physicians and Parents of Students requiring Medication in School*

In compliance with the rules and regulations of the New York State Education Department, you are required to complete this form to request that medication be administered to your child in school.

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Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Student's Address: \_\_\_\_\_

Student's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell)

Name of Drug(s): \_\_\_\_\_

Generic Name of Drug(s) if possible: \_\_\_\_\_

Dosage & Frequency: \_\_\_\_\_

May the student self-administer this medication in school?  Yes  No (If yes, complete section B below)

Expected Effect(s): \_\_\_\_\_

Possible Side Effect(s): \_\_\_\_\_

Diagnosis and ICD9 Code: \_\_\_\_\_

Date order is Effective: \_\_\_\_\_ Time Duration of Order: \_\_\_\_\_

Signed Physician's Name: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Physician's Address & Phone #: (pre-printed or office stamp preferred)

\_\_\_\_\_  
Street Address/PO BOX # City, State, Zip Code Phone #

Physician's NPI \_\_\_\_\_ License # \_\_\_\_\_  
Required Required

**A: Parent Request for School to Administer Medication:**

I hereby request that my child \_\_\_\_\_ be given the above medication in school as prescribed by the Physician.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**B: Request for Student to Self-Administer Medication in School: Emergency medication ONLY (inhalers, epipens, etc)**

\_\_\_\_\_ has been instructed in the proper method of self-administration of the following prescription medication: \_\_\_\_\_. It is our belief that this student is knowledgeable and responsible enough to carry, store, and use this medication during school and extracurricular hours. He or she has been instructed in and understands the purpose and appropriate method and frequency of the use of this medication.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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School Nurse: \_\_\_\_\_ License and NPI#s: \_\_\_\_\_