St. Michael's Academy

Standard Medication Order Form
For **ALL** Medications to be Administered During School Hours

Start date order is in effect: _____ Ending Date: _____

Student's Name: _____DOB: _____
Gender: M / F

This prescription form is to be completed by the ordering physician/physician assistant/nurse practitioner. Medications must be brought to school in the ORIGINAL packaging from the pharmacy with administering instructions. All medication orders must be renewed each academic year on a new order form.

Name of Medication: _____

Medical Diagnosis for the use of this medication: _____

Allergies: _____

Administration Route: _____Dosage: _____Time: _____ or PRN

PRN medication guidelines: Frequency _____ May repeat (please circle) x1 or x2

Specific indication/directions for PRN medications:

_____

_____

Side effects: _____

If this Rx is for an Inhaler or Epi-pen, can this student self-administer? Yes / No

(PRINT) _____ (Sign) _____
Physician/Physician Assistant/Nurse Practitioner Signature

Date: _____

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The following information is to be completed by the parent/guardian:

I request that my child be assisted in taking the above medication as prescribed by the PCP/PA/NP during school hours by an authorized person or is permitted to self-medicate themselves as prescribed by the physician and authorized by me.

I give my permission for the nurse to discuss with the prescriber and school staff the information on this form.

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Home Phone Cell Phone Emergency Phone

_____ _____
School Nurse Signature Date Received

_____ _____
Nurse Signature that verified orders with computer orders Date Verified