Houston County Schools Health Services

Doctor's orders for Prescription Medications: To be given/assisted at school

I request that my child be assisted in taking the medications described below at school by authorized persons or permitted to medicate himself as authorized by me and my Physician. I will assume any and all responsibility and liability for any problems with my child taking this medication at school, Including; possession of self-administered medications authorized by Physician.

I understand that:

Medication must be brought to school by a parent/ guardian or his/her adult designee in a properly labeled (original) prescription bottle with the student's name, prescription number, Name and dosage of medication, Administration route/date and other directions, pharmacy name/address, phone number & prescriber's name.

Student's Name_____ **DOB** _____

School_____ **Grade** _____ **Teacher**_____

***Parent/ Guardian Signature**_____ **Date**_____

Home Telephone # _____ Emergency #_____

Physician's Name_____ Phone Number_____

Address: _____ **Prescription Medications are to be taken as per**

_____ **Pharmacy Label and verified by MD Orders**

_____

**** The following must be filled out by Physician's office and signed by Student's Physician : ****

Diagnosis for Which Medication is given:_____

Name of Medication:
Form: **Dosage:**
Administration Route: **Orally** **Topically** **Inhalation** **Injection** **Rectal** **(Circle one)**
If Medication Is to be given Daily, At What Time:
If medication is to be given *"When needed"* **Please describe the indications:**
How soon can it be repeated?
Is Child authorized to medicate himself/ herself? **YES**_____ **NO**_____
Is the Student Capable of Self - Carrying Emergency Medications? YES_____ **NO**_____ **As per State Laws- Albuterol or Epinephrine**
***L*ength of time treatment is recommended:**
List Significant side effects Or Other Information:

_____

***Provider/ Physician Signature* / Date**