PHYSICIAN'S MEDICATION ORDERS FOR DISPENSING OF MEDICATION

It is the policy of Mountain Home School District to maintain signed orders for each prescription medication that school personnel are asked to dispense to students during school hours. The following are criteria for renewal of this form: 1) New school year; 2) Change in medication, dosage and/or time to be administered; 3) Any changes in the medication schedule (i.e., the medication has been discontinued temporarily and then restarted). The physician's or authorized prescriber's orders must be written and signed on this form or attached to the form**. The School District will not recognize orders written by parents/guardians**. Copies are not valid for additional prescriptions. The parent/guardian may not fill in the physician's name in the signature block.

Student's Name: _____

Date of birth, or age: _____ Grade: _____ School: _____

Date form received by the school: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication: _____

Name of Medication: _____

Form of medication/treatment:

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

This student **is permitted to** carry inhalers, epinephrine auto injectors, insulin, and blood glucose monitoring supplies, and topical ointments:

☐ No ☐ Yes

Physician Initials _____

(Please keep in mind; inhalers are readily accessible when stored in the office. Many students who carry respiratory inhalers do not report this and may present an emergent situation. Moreover, elementary students frequently lose their inhalers and/or are not aware when the vial is empty. If the student is permitted to carry this medication, this form must still be completed and turned into the office at the school so that we may be aware of the medication availability.)

Instructions (schedule and dose to be given at school): _____

_____

_____

Start: ☐ Date form received **Stop**: ☐ End of school year

☐ Other Date: _____ ☐ Other date/Duration: _____

☐ For episodic events only: _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (describe): _____

_____

_____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

Date: _____ Physician's Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy. Additionally, I give permission for the school to contact the prescribing physician and receive information as needed to implement the dispensing. District policy requires all medications to be brought to school in its **original container**. I release the school and its personnel from any, and all liability should adverse reaction occur as a result of medication.

Parent/Guardian Signature: _____ Date: _____

ADOPTED: May 24, 2004 Revised: April 17, 2007 Reviewed: July 15, 2008
Revised: December 18, 2012 Revised: December 20, 2016