**PHYSICIAN MEDICATION ORDER**

**FOR PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS**

A signed order from an authorized provider is required for your child to receive either prescription or over-the-counter medications at school, except occasional use of those covered by CASA’s standing orders which parent/guardian signature authorizes yearly on the Health Update.

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_

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| The following medication is to be given at school as indicated: | | | |
| Medication | Dosage | Route and Time | Side Effects |
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*\*Prescription medication must be in a container labeled by the pharmacist or prescriber.*

*\*Non-prescription medication must be in the original container with the label intact.*

*\*If an adult can’t bring the medication, email the nurse & have the student bring the medicine to the nurse in am*

*\*Students may not carry medications except for very limited, doctor-ordered, pre-approved situations.*

*\*The nurse will contact prescriber, as allowed by HIPAA, if a question arises regarding student/medication.*

*\* Refer to the Medication section of the student handbook for additional details.*

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| On field trips, student may self-administer under teacher supervision.  Provider Initials: \_\_\_\_\_\_\_\_\_\_ Parent/Guardian Initials: \_\_\_\_\_\_\_\_\_\_\_  The student was taught, has demonstrated responsible competence and has permission to carry and  self-administer their **inhaler/epinephrine auto-injector (circle medication(s**)) as ordered  Provider Initials: \_\_\_\_\_\_\_\_\_\_ Parent/Guardian Initials: \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health Care Provider (print) (MD/DO/NP/PA) Health Care Provider (signature)  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Discontinuation Date: \_\_\_\_\_\_ |

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| Parent/Guardian (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *\*Signing verifies that you give permission for the school staff to carry out the above prescribed plan in your absence*  *and relieve the Board and its employees of responsibility for the benefits or consequences for such medication and its*  *administration (Updated 8/2025, MO)* |