

ST ELIZABETH SCHOOL MEDICATION PERMISSION FORM

Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)				
Student Name:	Gender:	Date of Birth:	Grade:	Date of Order:
Reason for Medication:			Order Expires End of School Year	
Name of Medication:		Dose:		
Time to Give Medication:	Route:	Frequency of Medication:		
Delayed Opening Days (10:05 am) Administer Medication <input type="checkbox"/> Omit Medication <input type="checkbox"/>		Early Dismissal Days (12:45pm) Administer Medication <input type="checkbox"/> Omit Medication <input type="checkbox"/>		
Possible Side Effects:		Allergies:		
Special Instructions:				
<input type="checkbox"/> Student may carry and self-administer medication for asthma or other airway constricting conditions MD Initials : _____				
/				
Printed Physician/Prescriber Name and Signature		Parent/ Guardian Signature		
Physician Phone Number:		Parent/Guardian Phone Number:		

Medication Administration Record (For School Use Only)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
July																															
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

Name/Position

Initials

CODES: Chart reason

- X: School Closed
- N: None Available
- L: Late Arrival
- H: Dose Held
- A: Absent
- D/C: Medication Discontinued
- *: See Note for Details
- E: Early Dismissal
- : not administered per medical order
- R: refused
- S: Self Administer