DOUGLAS HIGH SCHOOL MEDICATION ORDER FORM

School Nurse: Melanie Gaucher, BSN, RN, BA
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STUDENT NAME: DATE OF BIRTH: GRADE:

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

NAME OF MEDICATION:

DOSE: FREQUENCY: TIME:

PRN (if applicable):

REASON FOR MEDICATION:

FORM OF MEDICATION/TREATMENT:
Tablet/Capsule Liquid Inhaler Injection Nebulizer Other

The student is both capable and responsible for self-administering this medication:
YES NO N/A

START DATE: END DATE:

ADDITIONAL INFORMATION:
Specific side effects, contraindications, possible adverse reactions to be observed:

Other medication being taken by the student:

SIGNATURE OF PHYSICIAN OR AUTHORIZED PROVIDER: DATE:

PHYSICIAN NAME (print) AND PHONE:

I have read and understand the Douglas Public Schools' Medication Policy. I give permission for (name of child) to receive the above named medication at school according to school policy. I understand that students are not allowed to carry medication on their person in school (exceptions: inhalers, epinephrine devices, enzymes and insulin at the discretion of their physician and parent/guardian).

PARENT/GUARDIAN SIGNATURE: DATE: