ST ELIZABETH SCHOOL MEDICATION POLICY AND MEDICATION PERMISSION FORM

Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)				
Student Name:	Gender:	Date of Birth:	Grade:	2019-2020 school year
Reason for Medication:		Order Expires End of School Year OR (date):		
Name of Medication:		Dose:		
Time to Give Medication: PRN	Route:	Frequency of Medication:		
Possible Side Effects:		Allergies:		
Special Instructions:				
☐ 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