ST ELIZABETH SCHOOL MEDICATION POLICY AND MEDICATION PERMISSION FORM

Reason for Medication: Dose: Sude School Year OR (date): Name of Medication: Dose: September Order Expires End of School Year OR (date): Name of Medication: PRN			N	<u> 1e</u> dio	<u>ca</u> tio	<u>n</u> Fo	orm/	Phy:	<u>sic</u> ia	<u>n'</u> s (Ordo	<u>er (</u> T	<u>o</u> Bo	<u> C</u> o	mpl	<u>eted</u>	by l	Phys	iciar	<u>1/A</u> u	<u>th</u> or	<u>iz</u> ed	Hea	alth (<u>Care</u>	<u>Pro</u>	<u>vi</u> de	<u>er)</u>					
Name of Medication:														ate o													scho	ol yea	ar				
Time to Give Medication: PRN Route: Frequency of Medication:	Reason for Medication:																Ord	er Ex	pire	s En	d of	Scho	ool Y	'ear	OR (date):						
Possible Side Effects: Allergies: Special Instructions:	Name of M															Dose	e:																
Student may carry and self-administer medication for asthma or other airway constricting conditions MD Initials :	Time to Gi	Time to Give Medication: PRN Route:														Frequency of Medication:																	
Student may carry and self-administer medication for asthma or other airway constricting conditions MD Initials :	Possible Side Effects:															Allergies:																	
Printed Physician/Prescriber Name and Signature	Special Ins	truct	ions	:																													
Printed Physician/Prescriber Name and Signature																																	
Parent/Guardian Phone Number: Parent/Guardian Phone Number:	☐ Student r	nay (carry	y and	self	-adn	ninis	ter n	nedio	catio	n for	asth	ıma (or ot	her a	airwa	y co	onstr	icting	g cor	nditio	ons I	MD]	Initia	als:								
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Medication Administration Record (For School Use Only)		Printed Physician/Prescriber Name and Signature																															
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July								N	/ledi	catio	n Ac	lmin	istra	tion	Reco	ord (For	Scho	ol U	se O	nly)												
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A: Absent S: Self Administer D/C: Medication Discontinued															4:-	D:		.1		S: 1	Self A	dmini	ster										