Reading Public Schools

MEDICATION ADMINISTRATION ORDERS AND CONSENT FORM

Name: ______________________________Grade:_______D.O. B._________
Address: ____ Sex: M/F
Allergies___________________________
Diagnosis:
____

1. Medication: _________________ Dosage________Frequency:__________
Date of Order: __________Time of Administration: ________Route:_________

2. Medication: __________________Dosage:________Frequency:__________
Date of Order: __________Time of Administration: ________Route:_________

3. Medication: __________________Dosage:________Frequency:__________
Date of Order: __________ Time of Administration: _______Route:_________

To be completed if not in violation of confidentiality:
Please list all medications the child is receiving, including those given during and after school hours.
Please include adverse reactions and side effects and any known allergies.

Signature of Physician:
____

Phone #____________________________ Date_____________________

PARENTAL CONSENT

____1. I give my permission to have the school nurse administer the medication ordered above.
____2. I give permission for my son/daughter to self-administer only inhalers and/or epi-pens at school and /or on field trips with physician’s signature. (Grades 5-12 only)
_____3. I give permission to the school nurse to share with appropriate school personnel, information relative to this student’s health status.
_____4. I authorize a teacher or chaperone deemed qualified by the school nurse to administer this/these medications on field trips.(N/A RMHS).
Please note: I understand that I may retrieve the medication from the school at any time, and that the medicine will be destroyed if it is not picked up following termination of the order or beyond the close of school.

Signature of Parent/Guardian: _________________________