

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: _____

