PHYSICIAN'S INSTRUCTION/CONSENT FOR MEDICATION ADMINISTRATION

(Please print)

Date Order Effective: _____ to: _____

To: Designated School Employee

Name of Student: _____ Date of Birth: _____

Address: _____

School _____ Grade _____ Teacher: _____

Physician's Name: _____ Phone Number: _____

Physician's Address _____

Diagnosis: _____

Routine medication: dose/route/frequency/duration:

_____

PRN medication: dose/route/frequency/duration:

_____

If a PRN medication, state condition under which medication is to be given:

_____

State the specific conditions under which contact should be made with you in relation to the condition or reactions of the student receiving the medication.

_____

_____

NOTE

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designated school employee and that you will accept direct communications from them regarding the administration of the medication.

_____ _____

Signature of Physician Date

Before prescribed medications(s) will be administered by the school or agent thereof, a Parent/Guardian Instruction/Consent for Medication Administration form must also be completed and returned to the school.

All prescription and non-prescription (over-the-counter) medications must be in the original container.

SOURCE: Amber Thompson, RN, BSN, MSN
Seymour Community School District
10 Circle Drive
Seymour, WI 54165
Phone#: (920) 833-2306
Fax #:
Black Creek Elementary/Middle School – 920-984-9303
Rock Ledge Primary Center – 920-833-5144
Rock Ledge Intermediate School – 920-833-9684
Seymour Middle School – 920-833-9376
Seymour High School (Health Office) – 920-833-5146