MEDICATION ORDER FOR WEST VIRGINIA PUBLIC SCHOOLS

Student Name:_____________________________________ Birth date:________________________

School Year:__________ School:_______________________________________Grade:__________

This form must be filled out and signed by a licensed prescriber and the parent/guardian for any prescribed medication to be given in the school setting. A separate order is required for each medication and orders are good for the current school year only. All medications changes (dosage, time, etc.) require the completion of another form. A photograph of this student may be taken to assist in the correct administration of medication. Medication may be given by unlicensed school personnel to whom the nurse has delegated medication administration and trained to administer medication. All medication must be sent to school in the original container from the pharmacy bearing the student's name.

Name of medication:____

Reason for medication administration:____

Dosage:_____________________________ Route or method of administration:_________________

Time to be administered:____

Side effects to watch for:____

Comments/Special instructions:____

Student allergies:____

**If rectal diazepam, may this medication be administered by unlicensed personnel? Yes No (circle one)*

**May this student self-administer this medication if permitted by county policy? Yes No (circle one)*

**May this student carry this medication on their person if permitted by county policy? Yes No (circle one)*

Prescriber's Name (please print):__________________________________Phone:________________

Prescriber's Address:____ Fax:_________________

Prescriber's signature:____ Date:________________

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I understand that, whenever possible, all medications should be given at home. I give permission for ____ to take the above medication at school according to county policy. I also understand and agree that the school nurse may talk with the clinician and his or her staff as well as school personnel regarding the student's condition and administration of this medication and its effects.

Parent/Guardian signature to approve administration of medication:________________________________

Daytime phone number:_____________________________________ Date:___________________________