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:____________________

MARSHALL COUNTY SCHOOLS

Physician Standing Orders to Dispense Non-Prescription Medication(s)

Student Name: ______________________________ DOB: ____________ School year______

The above student may be administered the following non-prescription medications/preparations on as "as needed" basis at the discretion of the school nurse:

______ **Acetaminophen** *(Tylenol)* ______mg every ______ hours for pain or temperature greater than 100 degrees. *(If student has a fever, parent will be contacted and student will be sent home.)*

______ **Ibuprofen** ______mg every ______ hours for pain or temperature greater than 100 degrees. *(If student has a fever, parent will be contacted and student will be sent home.)*

______ **Allergy Medicine** (specify:__________________): ______mg every _______ hours for nasal stuffiness WITHOUT fever or respiratory distress.

______ **Throat lozenges/cough drops** as needed for sore throat or cough.

______ **Tums** One or two tablets every ______ hours for upset stomach WITHOUT fever.

______ **Calamine Lotion** Apply ______ times per day as needed for minor skin irritation, insect bites, or poison.

______ **Benadryl Topical** Apply to affected area as needed for minor burns, cuts, scrapes, or skin irritations.

______ **Burn Cream/Ointment** Apply thin layer to skin as needed for burns.

______ **Lip balm or Vaseline** Apply as needed to dry, chapped lips.

______ **Bactine** For minor cuts and scrapes, apply as needed after cleaning area with soap and water.

______ **Bacitracin Topical Ointment** Apply thin layer to minor cuts, scrapes, burns as needed.

______ **Sting Kill** Apply topically as needed to stings/bites from bees, wasps, mosquitoes, spiders.

______ **Other:** ____

Please Note: All medications must be provided to the school nurse in the original package by the parent/guardian.

Physician's Name (please print):________________________________ **Phone:** ______________

Physician's Signature: ____ **Date:** ______________

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

Parent/guardian signature to approve administration of medication(s): ______________________________

Date: __________________ Daytime phone number: ______________________________