HEALTH OFFICE
BROCTON CENTRAL SCHOOL
BROCTON, N.Y. 14716
PHONE: 792-9112
FAX: 792-2260
MEDICATION ORDERS

A. To be Completed by Parent:

I request that my child_____grade_____receive the medication prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the labeled pharmacy container. I understand that the School Nurse or other designated person will administer the medication. I give my permission for information regarding this treatment to be shared with the physician and other school staff who have a need to know.

Signature_____date_____
Telephone: Home_____Work_____

B. To be Completed by Licensed Health Care Prescriber:

I request that my patient receive the following medication:_____

Diagnosis_____
Dosage_____Frequency_____
Route of Administration_____Time to be taken in school_____
Duration of treatment_____
Possible side effects and adverse reactions_____
Other recommendations_____

C. Self-Medication Release Form (optional)

The above named child has been instructed in the proper use of the following medication procedures:_____
We (physician's signature)_____and (parent's signature)_____request that (child's name)_____be permitted to carry the medication on his person or to keep same in his locker as we consider him responsible. He has been instructed in and understands the purpose and appropriate method and frequency of use.

Name of Prescriber_____
Signature_____Date_____
Address_____Phone_____