SPRINGFIELD PUBLIC SCHOOLS
Prescription/Medication Form

Standard Medication Order Form
For ALL Medications to be Administered During School Hours

Students Name**:** _____ _____DOB**:** _____
Gender: M / F **Last** **First**

Prescription Form to be completed by the ordering Physician/Nurse Practitioner. Hours of medication administration in the schools will be between the hours of 11:00 and 12:30.

Start Date Order is in effect**:** _____ Ending Date**:** _____
(All Medication orders need to be renewed each academic year on a separate order form.)

Name of Medication**:** _____

Medical Diagnosis for use of this Medication**:** _____Allergies_____

Administration**:** Route**:** _____ Dosage**:** _____ Time**:** _____ or PRN
PRN Medication guidelines: Frequency: _____ (Please circle) May repeat: x 1 or 2.
Specific indication/directions for PRN Medications:
_____
_____

Side Effects: _____

If this RX is for an Inhaler or Epi-pen can this student self-administer? (Please circle) YES / NO

(PRINT)_____ **(SIGN)**_____ _____
Physician/Nurse Practitioner Signature **Date Ordered**
Please provide physician's office stamp in space provided:

I request that my child be assisted in taking the above medication as prescribed by the PCP/NP during school hours by an authorized person or is permitted to self-medicate themselves as prescribed by the physician and authorized by me.
I give my permission for the nurse to discuss with the prescriber and school staff as necessary information on this form.

_____ _____
Parent/Guardian Signature **Date**

Home Phone_____ **Cell Phone:** _____

Emergency Phone: _____

_____ _____
School Nurse Signature **Date Received**

_____ _____
Nurse Signature that verified orders with computer orders. **Date Verified**