

**Frontier Regional School**  
**Medication Order Form to be completed by Licensed Prescriber**

Student name \_\_\_\_\_ Date of Birth \_\_\_\_\_

ALLERGIES \_\_\_\_\_

Name of Licensed Prescriber \_\_\_\_\_ Phone \_\_\_\_\_

List of Prescribed Medications (Home and School Medication (s))	Dosage, Route, Frequency
_____	_____
_____	_____
_____	_____

Date of Order (s) \_\_\_\_\_ **Discontinuation Date** \_\_\_\_\_

Side Effects, contraindications or possible adverse reactions:

**CONSENT FOR SELF ADMINISTRATION** (provided the school nurse determines it is safe and appropriate).

Yes \_\_\_\_\_ No \_\_\_\_\_

Signature of Licensed Prescriber \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian authorization fro prescribed medication administration.

I consent to have the school nurse administer medication prescribed. I give permission to the school nurse to share information relevant to the prescribed medication administration when appropriate for my child's health and safety. I understand medication will be destroyed if it is not picked up within a week following termination of the order or at the finish of the school year.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_ \

Relationship to student \_\_\_\_\_

