SONOMA VALLEY UNIFIED SCHOOL DISTRICT

MEDICATION ORDER FOR SCHOOL

Student/Patient Name:_____ DOB:_____

School_____ Teacher_____ GR/RM_____

A. PHYSICIAN ORDER

Diagnosis or Reason for Medication: _____

Medication	*Dose*	*Route*	*Time(s)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Possible reactions or other serious considerations regarding medication(s):

_____

_____

ORDER IS GOOD FOR ENTIRE SCHOOL YEAR *unless* otherwise noted here:_____

For ASTHMA INHALERS ONLY:

1. Child may carry inhaler and self medicate ☐ Yes ☐ No
2. Child to have self-paced PE ☐ Yes ☐ No

B. PHYSICIAN SIGNATURE:_____ **DATE:**_____

_____ _____

Physician Name (please print) ***Phone***

C. PARENT REQUEST AND AUTHORIZATION:

I request that my child _____, be assisted in taking the above medication at school as prescribed. I authorize the school nurse or designated school personnel to administer the medication. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability of loss of any sort because of, or arising out of, the acts or omissions of the District or its employees with respect to this medication. I give the school nurse authority to communicate and exchange medical information related to this medication order with the ordering physician.

I understand that the school must receive the medication in a container with a pharmacy label that indicates the child's name, medication, dosage, route, time to administer, and the prescribing doctor's name (or, if an over-the-counter medication was ordered, the medication must be in the original container/packaging).

I understand that medication cannot be taken at school unless the school has received each of the following: (a) Current physician order (order has to be renewed every school year), (b) parent/
guardian signature, and (c) properly labeled medication.

PARENT/GUARDIAN SIGNATURE_____ **DATE**_____