Batavia Public Schools #101
ORDER FOR ADMINISTRATION OF MEDICATION
Please complete in detail. Physician and parents must sign this order.

STUDENT'S NAME:____________________________________ BIRTH DATE_______________

ADDRESS:____

SCHOOL_____________________________ GRADE______ TEACHER (K-5 only) ____________

Medication (ONE PER FORM) _________________________________ Dosage__________Route________

Time/Interval to be given: ____

Diagnosis requiring medication: ____

Intended effect(s) ___________________________ Adverse effect(s) ___________________________

Start Date________________________________ Discontinue Date _________________________

___________________________________ ________________________________
Signature of Licensed Prescriber **Date of Signature/order**

Print (or stamp) Name and Address of Prescriber:
____
____
____

Office Phone: ___________________________________ FAX______________________________

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INHALER AND EPIPEN SELF ADMINISTRATION: I certify that ___________________________ has been instructed and has demonstrated proper use and self-administration of ____________________ medication. S/he may carry this medication at school. Parents agree to follow district guidelines for self-administration of inhaler/epipen.

___________________________________ ___________________________
Physician's Signature **Date**

___________________________________ ___________________________
Parent/Guardian Signature **Date**
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PARENT/GUARDIAN:

I give permission to Batavia School District #101 to administer/supervise the medication described in accordance with the School District's Regulations Governing the Administration of Medications in the schools.

___________________________________ ______________________________
Parent/ Guardian Signature **Date**

Day Phone ___________________________ Cell phone(s)____________________________________

___________________________ ___________________________________

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