CENTRAL COMMUNITY SCHOOL DISTRICT
PHYSICIAN ORDER FORM

Student: _____ DOB: _____
School: _____
Student's Diagnosis (all): _____
Student's General Health Status: _____
Medication to be given at School: _____
Desired Effect: _____
Amount per dose: _____ Time of each dose: _____
Route of administration: (check one): By mouth _____ Inhalation _____
Date to Begin: _____ Date to End: _____
List contraindications or child specific adverse effects to watch for at school:
_____
Call me if : _____
Other medication being taken at home: _____
Next office visit: _____
Allergies: _____

Use this section only for students who will administer their own medication: such as Students using an inhaler.

Has this student been adequately instructed by you or your staff and demonstrated Competence in self-administration of this medication to the degree that he/she may Self-administer his/her medication at school provided the school nurse has determined It is safe and appropriate for this particular student in this particular school setting:
_____ Yes _____ No

Comments: _____
_____
_____

_____ _____
Date Physician Signature

Physician name: (Please Print) _____
Office Address: _____ Office Phone: _____

Fax #: _____

CENTRAL COMMUNITY SCHOOL DISTRICT
PARENTAL CONSENT FORM

Student: _____ DOB: _____
School: _____
Student's Diagnosis (all): _____
Student's General Health Status: _____
Medication to be given at School: _____
Medications that are given at home: _____
Allergies: _____

Contact information:
Parent/Guardian: _____ Address: _____
Home Phone: _____ Cell phone: _____ Work Phone: _____
Other person to contact in case of emergency: _____
_____
Have you received a copy of the Central Community School District Policy on Medication Administration at school? ☐Yes ☐No
Do you give permission for the school nurse to share with designated trained unlicensed Personnel information about your child relative to medication administration as the nurse deems necessary? Yes ☐No Are there any restrictions on this release? _____|
Do you understand that you may retrieve medication from the school at any time and medication will be destroyed after you have been notified if it is not picked up at the end of the school year? ☐Yes ☐ No

All above answers must be "Yes" before the medication will be administered at school by the unlicensed trained personnel.

Use this section only for students who will administer their own medication: such as Students using an inhaler.

Do you give permission for your child to self administer medication if the school nurse Determines it is safe and appropriate in the school setting? _____Yes ____ No
Do you believe that your child is sufficiently responsible and informed to administer His/her own medication? _____ Yes ____ No
Do you assume responsibility for your child's actions in his/her self-management of Medication at school? ____ Yes ____ No
Do you understand that regular medication orders must be provided for student who Self administer medications at school? _____ Yes _____ No

I understand and agree that the Central Community School District and its employees are not responsible for any unintentional mistakes or oversights in keeping or administering medication to my child. I agree to hold the School Board Free and harmless from liability from injuries which might occur as a result of the administration of medications by school employees.

_____ _____
Date Parent/Guardian Signature