MAYO CLINIC HEALTH SYSTEM

Physician Order for School Medication Administration

Student Information

Name of Student	Birth Date
Name of School	Grade

To Be Completed By Physician

Medication(s)	Dosage	Duration	Instructions/Time to be given at School
		From: To:	
		From: To:	
		From: To:	

Diagnosis: _____

_____

Child may carry and self administer medication according to instructions above: Yes ☐ No ☐

Provider Name	
Provider Signature	Date
Clinic Address	Clinic Phone Number

To Be Completed By Parent/Guardian

- I give permission for my child to receive the above medication(s) as directed and for the school nurse to contact the physician directly if there are any questions relating to the medication treatment.
- I request that this medication be administered at school by designated employee(s) and release said employee(s) from liability.
- I must provide medication(s) in the original container labeled clearly with the child's name and prescribing information.
- I will provide the school with a new School Medication Administration form whenever there is a change in the medication or its instructions.
- I will notify the school in writing when the medication is discontinued and I will pick up the medication.
- I will pick up the medication at the end of the school year.
- I authorize school personnel to contact my child's physician if needed.

Parent/Guardian Signature	Phone Number	Date

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