School District of Glenwood City

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Glenwood City, Wisconsin 54013
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# Physician Order for School Medication Administration

**Student Information**

| Name of Student: | Birth Date: |
|---|---|
| School District of Glenwood City | Grade: |

**To Be Completed By Physician**

| Medication(s) | Dosage | Duration | Instructions/Time to be given at School |
|---|---|---|---|
| | | From:<br>To: | |
| | | From:<br>To: | |
| | | From:<br>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 Signature: | Phone Number: | Date: |
|---|---|---|
| | | |