Upper Columbia Academy

Medication Standing Orders

Licensed Health Care Provider Request

Date _____

Student Name _____ _____ _____ _____ _____ _____

Last First Middle Gender Grade Age Birth Date

Name of Medication	Dosage	Diagnosis for which Medication given:	Method of Administration	Administration Schedule

I request and authorize that the above-named student be administered the above-identified medication(s) in accordance with the instructions indicated above as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by designated school personnel who may be medically untrained.

_____

Licensed Health Professional's Name (Printed) Licensed Health Professional's Signature Date

_____

Licensed Health Professional's Email Phone Number

This Portion is to be completed by the Parent/Legal Guardian

I certify that I am the parent/legal guardian of the above-named student and request and authorize the school to administer the above-identified medication(s) to the student in accordance with the prescription or doctor's instructions for the period beginning _____ through _____ (not to exceed one school year). Medication will be supplied to the school in the original container.

_____

Parent/Legal Guardian's Signature Date

For School Nurse Use Only

The above-named student may carry and self-administer the following medications:

_____ _____

_____ _____

_____ _____

_____ _____

School Nurse's Signature Date Parent/Legal Guardian's Signature Date