Horseheads Central School District
PHYSICIAN'S ORDERS FOR MEDICATION

Patient Name: _____ School: _____
Address:_____ Grade: _____
_____ DOB: _____ Sex: ___

Name/Generic Name of Drug: _____

Dosage/Frequency: _____

Expected Effect: _____

Possible Side Effects: _____

Diagnosis: _____

Time Duration of Order: _____

Effective Date of Order: _____

SIGNATURE REQUIRED FOR ONE OF THE FOLLOWING:

A: Parent Request to School to Administer Medication
I hereby request that _____
be given the medication above as prescribed by the physician.

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date

B: Request for Student to Self-Medicate *(Requests shall be considered on a case-by-case basis and are reserved for students (grades 5-12 only) with life-threatening conditions where life-sustaining medication is required.)*

_____ has been instructed in the proper method of self-administration of the following prescribed medication:
_____

It is our belief that this student is knowledgeable and responsible enough to carry*, store*, and use said medication during school and extracurricular hours. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the medication.

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date

*In some situations, students may be required to store the medications in the nurse's office during the school day.

Approved: June 4, 2001; Revised and Approved: April 17, 2003; April 5, 2007; Sept. 14, 2011