# Medication Order for West Virginia Public Schools

Student Name: _____ Birth date: _____
Last First MI

Address: _____ Age: _____

Telephone Number: _____ School Year: _____ Grade: _____

School: _____ (Homeroom) Teacher: _____

**This form must be filled out and signed by a licensed prescriber and the parent/guardian for any prescribed medication to be given in the school setting. A separate order is required for each medication and orders are good for the current school year only. All medication changes (dosage, time, etc.) require the completion of another form. A photograph of this student may be taken to assist in the correct administration of medication. Medication may be given by unlicensed school personnel to whom the nurse has delegated medication administration and trained to administer medication. All medication must be sent to school in the original container bearing the student's name.**

Name of medication: _____ Expiration date of order: _____

Reason for Medication Administration: _____

Dosage: _____ Route or method of administration: _____

Time to be administered: _____

Side effects to watch for: _____

Comments/Special Instructions: _____

Student Allergies: _____

** If rectal diazepam, may this medication be administered by unlicensed personnel? Yes or No (circle one)*

**May this student self-administer this medication if permitted by county policy? Yes or No (circle one)*

**May this student carry this medication on his/her person if permitted by county policy? Yes or No(circle one)*

Prescriber's Name (please print): _____ Telephone Number: _____

Prescriber's Address: _____ Fax Number: _____

Prescriber's Signature: _____ Date: _____

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**I understand that, whenever possible, all medications should be given at home. I give permission for _____ _____ to take the above medication at school according to county policy. I also understand and agree that the school nurse may talk with the clinician and his or her staff, as well as school personnel, regarding the student's condition and administration of this medication and its effects. I further understand that the school, county school board and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of asthma medication by the student and agree to indemnify and hold harmless the school, the county board of education and its employees or guardians and agents against any claims arising from the self-administration of asthma medication.**

Parent/Guardian signature to approve administration of medication: _____

Day time phone number: _____ Date: _____