

**Tuscarora School District**

**School Health Service**

Private Health Care Professional's order for administration of **Prescription and Non-Prescription Medication** during school hours.

Student Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Route: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time: \_\_\_\_\_

Duration of Medication Administration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Restriction/Limitation of Normal Activities (ex. Gym, Shop, etc.) YES \_\_\_\_\_ NO \_\_\_\_\_

Please Specify \_\_\_\_\_

\*\*Epi-pen/Inhaler: Student Capable of Self-Administration YES \_\_\_\_\_ NO \_\_\_\_\_

\*\*Medical Permission for Student to Carry Epi-pen/Inhaler YES \_\_\_\_\_ NO \_\_\_\_\_

\*Health Care Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider's Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_

\*I hereby relieve the Tuscarora School Board and TSD employees of any liability for medication administration and grant permission to the Tuscarora School District personnel to administer or supervise the self-administration (Inhalers, Epi-pens) of the above-mentioned prescription medication/over-the-counter medication, as directed, during school hours to my child.

\_\_\_\_\_

Date

\_\_\_\_\_

\*\*Parent/Guardian Signature

Parents, you may have your doctor fax this form to me at \_\_\_\_\_