Valley Collaborative
Nursing Department

PHYSICIANS MEDICATION ORDER FORM

Name of Student:_____Date of Birth:_____

Address:_____ Telephone #:_____

Physician/Clinic:_____Telephone #:_____

Allergies/Adverse medication reactions: _____

MEDICATIONS TO BE GIVEN DURING SCHOOL HOURS

Date	Medication & Dose	Route & Frequency	Treatment Purpose	Special instructions (Including parameters for vital sign monitoring, if needed)	Duration/Stop Date

Unless indicated by Physician, above medications may be administered by trained staff.

MEDICATIONS BEING TAKEN BY STUDENT AT HOME

Medication & Dose	Route & Frequency	Treatment Purpose	Prescribed by

(Use back of form if more room is needed)

Physicians Signature:_____Date_____

Parental/GuardianSignature:_____Date_____

Please note: This form will expire one year from date signed. Please inform Nursing Department of any changes. Please see School Nurse Roster for contact information.