Jal Public Schools  
Physician Order and Medication Authorization Form

Medication will be administered in the school ONLY when it is necessary for a student to remain in school. Medication should be sent to the school with or for a student ONLY WHEN IT IS AN ABSOLUTE NECESSITY.

The purpose of this policy is to ensure that students do receive necessary medication according to their physician’s orders and to ensure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to administer the medication when the school nurse is not available. Training is given to all school personnel who could be administering the medication.

Should you be asked to complete one of these forms, please read the form thoroughly and respond to ALL items. Contact the school nurse if you have any questions. THANK YOU

THIS form is for one medication/authorization AND is only valid for the current school year.

******************************************************************************

Student’s Name ______________________________________  Date: _________________

School: ______________________________________  Teacher: _________________________________

Allergies: ______________________________________________________________________________

PHYSICIAN’S ORDER

1. I have examined this student for (diagnosis) ________________________________________ and
   have determined she/he requires medication during school hours.

2. Name of medication _______________________________________ Dosage ________________

3. Time of administration ______________________ Duration of Administration_______________

4. Special instructions regarding this medication __________________________________________

5. Symptoms of Adverse Reactions ____________________________________________________

For use of inhalers: I believe this student is able and needs to carry and administer her/his inhaler for
debate asthma. Please check _____ YES _____ NO

The student has been instructed in the care/use of the inhaler. Please check ______YES _____ NO

Physician’s Signature ______________________________________  Date _____________________

Printed Name ____________________________________________ Phone ____________________

******************************************************************************

PARENT/GUARDIAN STATEMENT:

I/We, the parent(s) of ________________________________________________________________

( Student’s Name)

hereby request that this medication be given to my/our child according to the physician’s instructions.

I/We agree to furnish the necessary medication in a pharmacy/original labeled container, provide replacement
medication as necessary, and to provide a new physician’s statement if there is ANY change in the medication,
dosage, administration time, administration route, or special instructions regarding the medication. I/WE
understand that other designated personnel (other than the school nurse) will give medication to or supervise the
child with self-administration of inhalers.

Parent(s)/Guardian’s Signature: ________________________________  Date __________

Reviewed/Revised: June, 2009