Green Hills School Medication Administration Physician's Order & Log **To be completed for each medication.* School Year __2024-25__

In accordance with school policy, medication must be in a pharmacy-labeled container w/ the child's name, date, name of med, dosage schedule & physician's name. (Parent may request duplicate containers when prescription is filled). ***All meds must be brought to the school by the parent/guardian in the original container***. All meds must be counted by the school nurse, in the presence of the parent/guardian, and signed for. Permission will be valid **only** for the current school year.

TO BE COMPLETED BY PARENT:

Student: _____ DOB: _____ Grade/Teacher: _____

(1) Parent/Guardian & Phone: _____ (2) Parent/Guardian & Phone: _____

I request that the above-named child receive this medication as prescribed by our health care provider (HCP). This medication is to be furnished by me as required by the Board of Ed. policy. I understand that the district is rendering a service & does not assume any responsibility for this matter. I give permission for the administration of this medication by the school nurse and the sharing of information w/ appropriate staff. I also permit the release & exchange of info between the nurse & my child's HCP concerning my child's health & medication(s).

Parent signature _____ Date: _____

TO BE COMPLETED BY PHYSICIAN: *Please give the above named student the following:*

Medication & dosage: _____ Route: _____ Time(s) Given in School: _____ Start Date: _____ End Date: _____

Diagnosis: _____ Possible Side Effects: _____

Stamp of Physician: _____ Address: _____

Physician signature: _____ Date: _____ Phone: _____ Fax: _____

TO BE COMPLETED BY SCHOOL NURSE:

CODES: A (Absent) ♦ X (No School) ♦ E (Early Dismissal) ♦ F (Field Trip) ♦ N (No Med Available) ♦ O (No Show) ♦ W (Dosage Withheld)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept	X	X	X	X			X	X						X	X						X	X						X	X		X
Oct.					X	X						X	X						X	X						X	X	X	X		
Nov.		X	X				X	X	X	X						X	X						X	X					X	X
Dec.							X	X						X	X						X	X		X	X	X	X	X	X	X	X
Jan.	X			X	X						X	X						X	X						X	X				
Feb.	X	X						X	X						X	X						X	X						X	X	X
Mar.	X	X						X	X						X	X						X	X						X	X	
Apr.						X	X					X	X						X	X						X	X				X
May			X	X						X	X						X	X						X	X						X
June	X						X	X						X	X						X	X					X	X		X

Initials	Nurse Signature	Nurse Printed Name		Initials	Nurse Signature	Nurse Printed Name

Green Hills School Medication Administration Physician's Order & Daily Log *(Cont'd)* Student:___________________________

Date	School Nurse Notes (with signature)	Date	School Nurse Notes (with signature)