Howard County Public School System

SCHOOL HEALTH SERVICES
Medication Form/Physician's Order
(To be completed by Physician/Authorized Health Care Provider)

Student name: _____ Gender: ❑ M ❑ F Date of birth: __/__/____ Grade: _____ Date of Order: __/__/____

School: _____ Order expires end of school year **or** (date):_____

Reason for medication: _____ Order valid for current year including summer school (Check if appropriate) ❑

Name of medication: _____ Dose: _____ Strength: _____

Time to give medication: _____ Route: _____ Frequency of Medication: _____ Date Med. Expires: __/__/____

Possible side effects: _____ Allergies: _____

Special Instructions: _____

❑ May carry/self administer meds for airway constricting diseases ❑ May carry/self administer OTC meds on field trips ❑ MD Initials

Physician name (print): _____ Physician signature _____ Parent signature: _____

Medication Administration Record (For School Use Only)

Nurse Reviewed **Date(s) Reviewed**

	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
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

Name/Position	Initials	Name/Position	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Nursing assessment has been completed for student self administration _____

Student may/may not self administer (check one) ❑ Yes ❑ No RN Signature Date

Codes: Chart reason (see High School manual)

X: School Closed
A: Absent
N: None Available
NS: No Show to HR
D/C: Medication discontinued
L/E: Late arrival/early dismissal
FT: Field Trip
R: Refused
O: Omitted
H: Dose Held

HS6401-01-39513035

Howard County Public School System

Medication Receiving/Disposing Record

Student name: _____ School: _____ Grade: _____

Date	Medication Name/ Dose Equipment	Current Count	Number Received	# Wasted, Returned or Destroyed	New Total	Parent Signature	Health Room Staff Signature	Comments

HS6401-01-39513035