Eunice Public Schools

PROVIDER ORDER / MEDICATION AUTHORIZATION FORM

Student Name: _____ DOB: _____

School: _____ Grade/Teacher: _____

PROVIDER ORDER **(please complete every item in this section)** **Date:**_____

1. I have examined this student for (diagnosis) _____and have determined that he/she **requires** medication during school hours.
2. Name of Medication: _____ Dosage: _____
   Route: _____ Time of Administration: _____ Duration:_____
3. Special instructions regarding this medication: _____
   _____
4. Contact me if the following signs/symptoms appear: _____
   _____
5. I believe this student is capable of carrying and administering his/her own medication at the appropriate time and in the appropriate way as per my instruction. ____Yes ____No

Healthcare Provider Signature: _____ Printed Name: _____

Phone: _____ Fax:_____ Email: _____

Address: _____ State: _____ Zip:_____

PARENT/GUARDIAN STATEMENT **(this document is in effect for the current school year only)**

1. I, the undersigned parent/guardian of the above named student, hereby request the school nurse or designee administer the above medication according to the healthcare provider's instruction.
2. If the healthcare provider believes my child is capable of carrying and administering his/her own medication at the appropriate time and in the appropriate way, I give my consent for my child to do so without supervision.
3. I agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement medication as necessary and to notify the school nurse immediately if the provider or medication prescription is changed or discontinued.
4. I authorize, as needed, the sharing of information related to my child's health between the school nurse (and designee) and the health care provider listed on this form. I understand without this authorization to communicate, these orders will not be implemented.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Work Phone _____ Cell Phone:_____

** It is policy that employees of EPS will administer medication only when absolutely necessary for a student to remain in school. The purpose of this policy is to ensure that students do receive necessary medications according to their physician's orders and to ensure maximum safety for all concerned. Your signature authorizes other school personnel (referred to as "designee" herein) to supervise your child with self-administration of medication when the school nurse is not available. If you have questions or concerns, please contact the school nurse. **

School Nurse Signature: _____ Date: _____ Time: _____