LAKE SHORE SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

MEDICATION ORDERS

DATE: _____

STUDENT NAME: _____ DOB: _____

DIAGNOSIS: _____

MEDICATION NAME: _____ DOSAGE: _____

ROUTE: _____ TIME: _____ FREQUENCY: _____

COMMENTS: _____

HEALTH CARE PROVIDER NAME: _____

HEALTH CARE PROVIDER SIGNATURE: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

PARENT/ GUARDIAN CONSENT

We grant permission for licensed school health professionals to administer this medication to our child following the medical providers written instructions.

PARENT/ GUARDIAN SIGNATURE: _____

DATE: _____