ARLINGTON CENTRAL SCHOOL DISTRICT

LICENSED HEALTH CARE PRESCRIBER'S MEDICATION ORDER

Student Name: _________________________________ D.O.B.: _____________

School: __________________________ Grade: _____ School Year: ________

Diagnosis: ____

Medication: ____

Dose & Frequency/Route of Administration: _________________________________

May carry/self administer metered dose inhaler: Yes No

May carry/self administer Benadryl/Epi Pen: Yes No

The reaction is anaphylactic _____, generalized _____, local _____.

Licensed Prescriber: ____

Signature: _____________________________________ Date: ________________

Address: ____

Telephone: ______________________________ Fax: _______________________

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PARENT AUTHORIZATION

I request that my child receive the medication prescribed by our licensed health care provider. The medication is to be furnished by me in a properly labeled original container from the pharmacy.

Parent/Guardian's Signature: _______________________ Date: _____________