



# Physician's Statement of Need/Prescriber's Medication Orders/Parental Request-Village Christian Academy

**Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Licensed Prescriber:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_

Whenever possible, medication should be scheduled at times other than school hours. NEW ORDERS REQUIRED at the beginning of each school year, and whenever there is a change in the medications, dosage or time given at school.

Trained unlicensed personnel may give oral medications, premeasured inhalants, topical ointments and emergency medications at school. The use of unit dose packaging is strongly encouraged.

**Diagnosis:** \_\_\_\_\_

**Medication (one per page):** \_\_\_\_\_

**Dosage (at school):** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Time to be given at school:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Date of order:** \_\_\_\_\_ **Discontinue Date:** \_\_\_\_\_

**List of contraindications to this medication or potential adverse effects specific to this student:** \_\_\_\_\_

**List of other medication(s) being taken by this student:** \_\_\_\_\_

**Comments/Other instructions:** \_\_\_\_\_

**Use this space ONLY for students who will require medications on or near their person for emergency situations. (Only Asthma inhaler, Epi-pen, insulin pump/blood sugar monitor and related equipment)**

It is necessary for this student to keep his/her medication with them at all times. YES \_\_\_ NO \_\_\_

This student has been adequately instructed by my staff and demonstrated competence in self-administration of this medication to the degree that he/she may self-administer and manage his/her medication at school.

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Physician's stamp**

### Parental Consent Section

I request that the trained school employee/Health Advisor/Nurse give \_\_\_\_\_  
as ordered by the Physician above: (name of Medication)

1. I agree that the initial dose of ordered medicine was/will be given at home and I will observe my child 12 hours for adverse reactions before asking school personnel to administer the medication.
2. If my child is to self-administer, I agree to maintain duplicate medication/supplies in the Health room.
3. I have read the policy in the school handbook regarding medication administration and agree to adhere to all policies
4. I agree to provide the medication in a container labeled by the pharmacy.

**This space is ONLY for epi-pens, diabetic supplies, and inhalers:**

**1. Do you give permission for your son/daughter to self-administer medication if the physician/school nurse/ health advisor determines it is safe and appropriate? Yes \_\_\_ No \_\_\_**

**2. Do you feel that you child is sufficiently responsible and informed to administer his/her own medication? Yes \_\_\_ No \_\_\_**

**3. Do you assume responsibility for your child's actions in his/her self-management of medication at school? Yes \_\_\_ No \_\_\_**

**Parent signature** \_\_\_\_\_ **Date:** \_\_\_\_\_