OVER

PHYSICIAN FORM

COATESVILLE AREA SCHOOL DISTRICT

MEDICATION ORDER FORM FOR ANY PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATIONS TO BE COMPLETED BY A LICENSED PROVIDER

Dear Physician,

According to "Guidelines for Pennsylvania Schools for the Administration of Medications and Emergency Care" by the Department of Health, school nurses need a "medical order" from a licensed provider to administer any prescription, over-the-counter, or herbal medicines. In the past we have required only parental consent. In order to simplify the procedure we've developed the form below which will be available to parents through the school nurse, in the student handbooks, and on the school district web site www.coatesville.k12.pa.us.

We look forward to working with you to provide the best care we can for our students. If you have any questions, concerns or suggestions, please do not hesitate to contact the School Nurse at 610-383-3780 ext 1

Barbara J. Friling, RN, CSN

Date:______________________________

Name of Student:____DOB___________

Name of medication:____

Dosage to be administered:____

Time medication is to be given:____

Date(s) medication is to be given:____

Condition being treated: ____

Signature of licensed medical provider:_______________________________________

Name of provider: ____

Phone number: ____

ANY MEDICINE OF ANY KIND SENT TO SCHOOL FOR ANY REASON REQUIRES A DOCTOR'S ORDER

SEE REVERSE SIDE FOR DIRECTIONS FOR MEDICATIONS ON FIELD TRIP

THIS FORM MAY BE FAXED TO THE SCHOOL NURSE AT 610-383-3784

Two sided Doctor Form

MEDICATIONS ON FIELD TRIPS

PLEASE NOTE THAT ALL MEDICATION TAKEN ON A FIELD TRIP MUST BE:

1. SENT FROM HOME
2. IN ORIGINAL CONTAINER
3. SINGLE DOSE (EXCEPTIONS WOULD BE AN INHALER OR INSULIN)

To be completed by the physician:

It is necessary for this student to take the following medication(s) during a field trip, lasting at least the entire school day (dose cannot be given before/after trip hours or skipped):

Student Name: ______________________________ Date of Birth: ______________

Medication: ______________________________ Time: ______________

______________________________ ______________

The student above _____ IS _____ IS NOT able to self-administer the above medication(s) as instructed.

Comments: ____

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Physician Name: ______________________________ Phone Nbr: ______________
(PRINT)

Physician Signature: ______________________________ Date: ______________

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Additional forms can be accessed on the C.A.S.D. web site www.coatesville.k12.pa.us