Student Medical Order Form
Wythe County Public Schools

Student School Name

Grade

Teacher Name

Date mm/dd/yyyy

Student Full Name Last, First, Middle

Student Date of Birth mm/dd/yyyy

Student Home Address

City

State

Zip Code

Licensed Medical Provider Name

Licensed Medical Provider Title

Provider Telephone Number (xxx)-xxx-xxxx

Date of Order mm/dd/yyyy

Discontinuation Date of Order mm/dd/yyyy

Medication

Route of administration

Dosage

Frequency

Time(s) of administration

Specific directions for administration:

Contradictions, possible adverse reactions, and/or special side effects:

Consent for self-administration by the student (with approval of parent/legal guardian and school nurse).

☐ No ☐ Yes

Signature of Licensed Medical Provider

Date mm/dd/yyyy

I request that the medication, names listed above, be administered to my daughter/son. The medical provider has explained to me the medication, its purpose, and possible complications.

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

Permission for the school nurse and physician to release information to each other pertaining to my daughter/son on this form.

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

Revised 03/2016