MEDICATION ORDER FORM

** one per medication prescribed*

Office Use Only

Classroom:_____

Teachers: _____

For Completion by Parent/Guardian:

Name of Student _____ Date of Birth _____

Reason for Medication (Please be specific) _____

I hereby request and authorize Tree House employees to administer prescribed medication as directed by the under-signed licensed health care provider. I grant permission for Tree House employees to exchange information with my child's health care provider as deemed necessary.

Parent/Guardian Signature _____ Date _____

For Completion by Physician/Advanced Practice Nurse:

Diagnosis _____Medication_____ Dosage _____ Route _____

Diagnosis _____Medication_____ Dosage _____ Route _____

Additional Medication Information (time of administration, signs/symptoms, etc.) _____

_____

Side effects of medication(s) _____

Restrictions on Daily Activities _____

Medication administration to begin on _____/_____/_____ and discontinue on _____/_____/_____.

I certify that this child would be unable to attend school if this medication is not administered during school hours and that this student is physically fit and able to attend school. _____ Yes _____ No (please initial)

As per Tree House policy permission for administration of medication in school will be given only when the student's attendance depends upon the timely administration of medication in school. We strongly encour-age that any medication that can be taken before or after school be so prescribed.

_____

Physician Signature **Date**

PHYSICIAN STAMP

(Must be present for plan to be valid)

_____

Telephone Number

This medication order is valid for the school year

Tree House Signature _____ Date order in effect _____