Oyster River Cooperative School District
Physician Medication Order

Date:_____ School:_____

Student's Name:_____DOB:_____

Diagnosis:_____
(If not a violation of confidentiality)

*Medication:_____

Directions:_____

_____

_____

*If the above medication is an asthma inhaler, Epi-pen, or insulin, does the student have permission to carry and/or self-administer his/her own medication?_____

Duration of time medication is to be administered:_____

Possible side effects:_____

_____

_____

Health Provider Signature:_____

Provider telephone number:_____

1) **No prescription medication will be given at school without this completed form.**
2) **The medication must be brought in its original container labeled by the pharmacy or health care provider.**
3) **All medication brought into school must be kept in the Health Office during school hours.**

Please return to the school nurse:

FAX #: ORHS=603-868-1355, ORMS=603-868-3469, MOH=603-742-7569, MW=603-659-8612

Last Modified 2/20/2015