WEST VIRGINIA DEPARTMENT OF EDUCATION
Council of School Nurses
ADMINISTRATION OF MEDICATION ORDER FORM

School Year_____ (Includes Extended School Year/Summer Programs)

Student Name: _____ DOB: _____ Grade: _____ School: _____

TO BE COMPLETED BY LICENSED PRESCRIBER (A separate administration of medication form is required for each medication)

Diagnosis: _____ Allergies: _____

Medication: _____ Dosage: _____ Time: _____ Route: _____

Intended Use: _____ Possible Side Effects: _____

Other Prescribed Medications: _____

Initial if emergency seizure medication can be administrated by trained unlicensed personnel _____

Initial if student may self-administer this medication in accordance to policy _____

Initial if student may carry this medication on his/her person in accordance to policy _____

Prescriber's Name (please print): _____ Telephone Number: _____ Fax Number: _____

Prescriber's Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that, whenever possible, all medications should be given at home. I give permission for my child to take the above medication at school according to county policy. I understand that a photograph may be taken and utilized to assist in the medication administration process. I further understand that the school, county board of education and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury, loss to persons or property, arising from the self-administration of medication by the student. I also agree to indemnify and hold harmless the school, the county board of education and its employees and agents against any claims arising from medication administration and/or self-administration of medications.

The medication must be hand delivered by the parent/guardian to designated school personnel, in original labeled pharmaceutical container or manufactured labeled container.

Parent/Guardian signature to approve administration of medication: _____

Date:_____