



Twin Falls School District #411 Support Services
301 Main Ave. W
Twin Falls, ID 83301

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MEDICATION ORDER FORM

SCHOOL: _____ GRADE: _____ TEACHER: _____

It is the policy of our school district to maintain signed orders for each prescription or non-prescription drug that school personnel are asked to dispense to students during school hours. This must be renewed each school year. The following form must be completed, signed, and returned to the child's school office before any medication can be dispensed.

STUDENT NAME: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN NAME: _____

DIAGNOSIS (OR REASON FOR MEDICATION): _____

PHYSICIAN'S NAME: _____ OFFICE PHONE: _____

MEDICATION NAME: _____

ROUTE OF ADMINISTRATION:

ORAL ____ TOPICAL ____ INJECTION ____ DROPS ____ OTHER (PLEASE SPECIFY): _____

DOSAGE TO BE TAKEN: _____

HOW OFTEN (OR AT WHAT TIMES): _____

POSSIBLE SIDE EFFECTS (IF SIGNIFICANT): _____

SPECIAL INSTRUCTIONS: _____

I give permission for my child to self-administer under the supervision of school personnel the medication described above. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above-named child or anyone else.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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THE FOLLOWING MUST BE COMPLETED BY A PHYSICIAN FOR PRESCRIPTION MEDICATION

I am recommending that the above-named student be allowed to self-administer or have the medication administered to them by trained school personnel the medication described above.

- ☐ Independently (the students must have had training and be proficient in self-administering medication, the student will be allowed to carry the medication with them)
- ☐ Under the supervision of school personnel (medication will be stored in the school office)
- ☐ Administered to them in emergency situations

PHYSICIANS SIGNATURE: _____ DATE: _____