SPRINGFIELD PUBLIC SCHOOLS
Prescription/Medication Form

Standard Medication Order Form
For ALL Medications to be Administered During School Hours

Students Name: _____________________  __________________
DOB: ________________
Gender: M / F                          Last                                     First

Prescription Form to be completed by the ordering Physician/Nurse Practitioner. Hours of
medication administration in the schools will be between the hours of 11:00 and 12:30.

Start Date Order is in effect: _________________ Ending Date: ___________________
(All Medication orders need to be renewed each academic year on a separate order form.)

Name of Medication: _____________________________________
Medical Diagnosis for use of this Medication: ______________Allergies __________

Administration: Route: ______  Dosage: ______  Time: ______ or PRN
PRN Medication guidelines: Frequency: ___________ (Please circle) May repeat: x 1 or 2.
Specific indication/directions for PRN Medications:
________________________________________________________________________
________________________________________________________________________
Side Effects: _____________________________________________________________

If this RX is for an Inhaler or Epi-pen can this student self-administer? (Please circle) YES / NO

(Print) __________________________ (Sign) __________________________ Date Ordered
Physician/Nurse Practitioner Signature

Please provide physician’s office stamp in space provided:

I request that my child be assisted in taking the above medication as prescribed by the PCP/NP during
school hours by an authorized person or is permitted to self-medicate themselves as prescribed by the
physician and authorized by me.
I give my permission for the nurse to discuss with the prescriber and school staff as necessary information
on this form.

________________________________________________________________________
Parent/Guardian Signature                                                                       Date
Home Phone __________________________ Cell Phone: __________________________

Emergency Phone: __________________________

________________________________________________________________________
School Nurse Signature                                                                      Date Received

________________________________________________________________________
Nurse Signature that verified orders with computer orders.  Date Verified

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