Student Medical Order Form
Wythe County Public Schools

Student School Name

Grade

Teacher Name

Student Full Name Last, First, Middle

Student Home Address

City

State

Zip Code

Licensed Medical Provider Name

Licensed Medical Provider Title

Provider Telephone Number
(xxx)-xxx-xxxx

Date
mm/dd/yyyy

Date of Order
mm/dd/yyyy

Discontinuation Date of Order
mm/dd/yyyy

Student Date of Birth
mm/dd/yyyy

Medication

Route of administration

Dosage

Frequency

Time(s) of administration

Specific directions for administration

Contradictions, possible adverse reactions, and/or special side effects

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Student Full Name Last, First Middle

Consent for self-administration by the student (with approval of parent/legal guardian and school nurse).

☐ No ☐ Yes

Signature of Licensed Medical Provider

Date mm/dd//yyyy

I request that the medications, names listed above, be administered to my daughter/son. The medical provider has explained to me the medications, its purpose, and any possible complications.

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

Permission for the school nurse and physician to release information to each other pertaining to my daughter/son on this form.

○ No ○ Yes

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

Revised 03/2016