MISSOURI DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
STATE SCHOOLS FOR SEVERELY HANDICAPPED
P.O. BOX 480
JEFFERSON CITY, MO 65102-0480

MEDICATION ORDER

This form must be completed, in total, in order for the student to receive either **prescription or non-prescription** medication(s) at school. The school is not allowed to make any changes to the healthcare provider instructions written on this form. Changes in the type of medication, dosage, or procedure necessitate that a new form be completed by the healthcare provider and be on file at the school the student is attending. The medication will be given by the **school nurse or a trained staff member**. The order will be in effect for no longer than **one school year.**

Student's Name	Date of Birth	State School

Name of Parent/Legal Guardian

Name of Medication	Dosage/Frequency	Route	**Times to administer at school**

Special Storage Instructions

Anticipated Reaction(s)

Name of Medication	Dosage/Frequency	Route	**Times to administer at school**

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Name of Medication	Dosage/Frequency	Route	**Times to administer at school**

Special Storage Instructions

Anticipated Reaction(s)

Healthcare Provider's Name (Print)	Healthcare Provider's Signature (M.D., D.O. or Nurse Practitioner only)	Date
Address		Phone Number