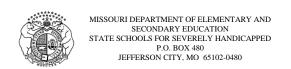
## MEDICATION ORDER



This form must be completed, in total, in order for the student to receive either prescription or nonprescription 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. Date of Birth Student's Name State School Name of Parent/Legal Guardian Dosage/Frequency Name of Medication Route Times to administer at school Special Storage Instructions Anticipated Reaction(s) Dosage/Frequency Name of Medication Route Times to administer at school **Special Storage Instructions** Anticipated Reaction(s) Name of Medication Dosage/Frequency Route Times to administer at school **Special Storage Instructions** Anticipated Reaction(s) Name of Medication Dosage/Frequency Times to administer at school Route Special Storage Instructions Anticipated Reaction(s) Healthcare Provider's Signature (M.D., D.O. or Nurse Healthcare Provider's Name Date (Print) Practitioner only) Address Phone Number

MO 500-0655 (04/07) 7-760-617