To be updated by parent/guardian/physician annually

	Physi	ician's	Order	
udent				Grade
edication/ Health Care Treatmen	t Dosage			Time(s) to be administered
tended effect of this medication				Expected side effects, if any
Other medications the student is to	aking			
1) May student self-admin medical training?	nister medication u	ınder sup	ervision (of school personnel who do not have
The state of the s	(Please circle)	YES	NO	
 For ASTHMA and ALI I certify that this stude and is capable of self-a 	nt has been instru	cted in th	e use and	self-administration of this medication of the medication of the medication of the medication.
	(Please circle)	MEG	NO	
I also request that this during school hours an of the medication as ne	student be allowed	YES to carry lated act	NO the above ivities in o	-described medication on their pers rder to facilitate the self-administra
I also request that this during school hours an	student be allowed	to carry lated act	the above	-described medication on their pers rder to facilitate the self-administra
I also request that this during school hours an of the medication as new	student be allowed ad during school-re eded. (Please circle)	to carry lated act	the above ivities in o	-described medication on their pers rder to facilitate the self-administra Date Signed
I also request that this during school hours an of the medication as need that the medication as need that this school hours and the medication as need to be a school of the medication as need to be a	student be allowed ad during school-reeded. (Please circle)	to carry lated act	the above ivities in o	rder to facilitate the self-administra
I also request that this during school hours an of the medication as need to be medicated as needed to be need	student be allowed ad during school-reeded. (Please circle)	to carry lated act	the above ivities in o	rder to facilitate the self-administra Date Signed
I also request that this during school hours an of the medication as need the medication as	student be allowed ad during school-reeded. (Please circle)	to carry	the above ivities in o	Date Signed Emergency telephone number City, State, Zip Code
I also request that this during school hours an of the medication as need the medication in the medication is required. Administration Instructions: Physician's / Prescriber's Signatur Physician's / Prescriber's Name (Paddress Medication Authorization	student be allowed ad during school-reeded. (Please circle) PRINT) approved or de (Please circle one	to carry elated act YES	the above ivities in o	Date Signed Emergency telephone number City, State, Zip Code this day of
I also request that this during school hours an of the medication as need the medication as need the medication as need to	student be allowed ad during school-reeded. (Please circle)	to carry elated act YES	the above ivities in o	Date Signed Emergency telephone number City, State, Zip Code