MEDICATION ORDER FORM

Student Name: _____ D.O.B: _____

Dear Physician:

If at all possible, we prefer that any medications for Vista students be prescribed for times outside of the school day (9 AM – 3PM). If a medication **must be** taken at school, we prefer it to be scheduled for 12:00 Noon. When starting a new medication, the first three doses must be administered at home.

Please indicate the following information for each medication **(both prescription and over-the-counter)** that must be administered during the day at The Vista School.

Medication	Dosage	Route	Time	Duration	Diagnosis or Condition

Does the medication require the student to have limitations, such as not participating in specific school activities? Physician, please specify:

_____

_____

_____

Does the medication have possible side effects or contraindications? Physician, please specify:

_____

_____

_____

_____ _____

Physician Signature Date

_____ _____

Physician Name (printed) Phone Number

Revised May, 2014