Parkwood Health Office

Parkwood Elementary
1815 N 155th St
Shoreline, Wash. 98133
FAX – 206-393-4158
Phone – (206) 393-4153
Attn: School Nurse

Student ____

Birthdate _________________ Age________Grade_______

Parent(s) Guardian(s)______________________________

Address_______________________________Phone_______

PHYSICIAN'S ORDERS FOR MEDICATIONS FOR EXTENDED FIELD TRIPS

This INCLUDES over-the-counter medications. Please list the **24 hour medication needs** for daily as well as medications the student may take on an "as -needed" basis.(Tylenol, Imodium, Dramamine, Midol etc.)

I request to have a designated staff member administer the following medication(s), for the above-named student according to the following directions:

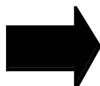
Medication	Dosage	Admin. method	Time (hour) to be given

Date to start medication______________________Date to discontinue medication ___________________________

This medication is being prescribed for the following reason(s) ____

Possible side effects____

Other comments____



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Signature of student's physician Date Phone

____
Printed Name of Physician

PARENT/GUARDIAN REQUEST FOR MEDICATION ADMINISTRATION FOR EXTENDED FIELD TRIP:

I request a designated staff member, to administer the above medication(s) as directed by

____
(name of physician) **(physician phone number)**

I accept responsibility for supplying in the original container (prescription bottle or over-the-counter container), and for immediately notifying the school nurse (or principal) of any change in these instructions.

I give my consent for the confidential information contained on this form to be FAXed to the above named school.

I understand that my name on this form constitutes a waiver by me to the school or staff member for liability for untoward reactions when the medication is administered in accordance with the above directions.

____ ______________________
Signature of Parent/Guardian **Date**