PCA

PRESCRIPTION MEDICATION ADMINISTRATION ORDER

Name: _____DOB: ____/_____/_____

Medication/Dose: _____

Route: _____

Frequency: _____

Time: _____

Reason: _____

Does this medication need to be taken with food or on an empty stomach?:

_____

Are there any other instructions for administration?:

_____

If an Emergency Medication, does student have permission to self-carry?:

Y N

Provider Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____