SCHOOL NAME

ADDRESS
TELEPHONE
FAX

VERBAL MEDICAL ORDER – only for School Nurse/Associate School Nurse use

TO: _____ Student Name/DOB

_____ _____

_____ _____

Faxed orders with licensed provider electronic signature and initialed by sending RN is/ is not acceptable (please circle your choice)

New MEDICATION, SERVICE And/or TREATMENT ORDERED
For meds specify details, including end date:

Start Date	**End Date**	**MEDICATION *CHANGES* Medication Name**	**Strength of med.**	**Dose**	**Route**	**Time**

SCHOOL NURSE: _____

SIGNATURE/TITLE OF SCHOOL NURSE ACCEPTING ORDERS:
_____ DATE: _____

PRINTED NAME OF Licensed Provider:
_____DATE: _____

SIGNATURE OF Licensed Provider:
_____

This order is valid for one dose only until signed and dated by licensed prescribing provider