PEGASUS MEDICATION ORDER FORM

**TO BE COMPLETED BY LICENSED PRESCRIBER & PARENT

(One prescription medication per form)

Student's Name: Date of Birth: Sex:

Address:
(Street) (City/Town) Grade:

Pertinent Medical Condition(s):

Allergies:

Name of Licensed Prescriber: Title:

Telephone Number:

Consent for Self Administration (Inhalers only) yes no
(*Provided Pegasus nurse deems it safe and appropriate)*

Administration of Prescription Medication/Other over the Counter Medication:

Name of medication:

Dosage: Route of Administration:

Frequency: Time(s) of Administration:

Other medication taken by the student:

I give permission for the Pegasus Nurse or other Pegasus staff member to administer the above medication to my child.

Licensed Prescriber's Signature: Date:

Parent's Signature: Date:

****Please note: Medication must be delivered by an adult to a Pegasus staff member in its original container. Prescription medications MUST have the pharmacy label attached.**