Washoe County School District

Student Health Services

Medication Clarification
(This is NOT a medication order form)

Dear Health Care Provider: _____

Your Patient, _____ DOB, _____ is a student at my school.

The medication taken at school is administered from a container which states: _____

_____

Medication for school use is requested as follows: _____

_____

Please provide clarification in the spaces provided below for the item(s) checked. Sign (stamped signatures are not accepted) and fax promptly to the school nurse.

☐ Specific dosage: _____

☐ Specific time(s) to be given. Please do not use "BID", "TID", etc.: _____

☐ "With lunch" (time varies with student's schedule): _____

☐ Indication for PRN use (e.g., for headache, cough, wheezing, itching): _____

☐ Interval between dose (e.g., every 4 hours): _____

☐ Other:

(_____) : _____

The Washoe County School District has established specific procedures for medication safety per the opinion/recommendations of the Nevada State Board of Nursing.

Provider's Name (print)	Provider's Signature – Stamp not accepted	Date

Provider's Phone: _____ Provider's Fax: _____

School Nurse (print)	School Nurse Signature	Date

School Nurse Phone: _____ School Nurse Fax: _____