Medication/Order Authorization

This form will detail the necessary requirements for the University Health Center to store and administer a student's medication. Please fax to (540) 568-6176.

Name of Student: ______________________________

Date of Birth: ______/______/____________

Name of Prescribing Provider: ______________________________

Address of Prescriber: ______________________________

Telephone: ____________________ Fax: ____________________

Name of Medication: ______________________________

Dosage: ____________________

Route: ____________________

Frequency: ____________________

Length of therapy: ____________________

ICD 10 Code(s): ______________________________

Special Instructions: ______________________________

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_____ Student will bring medication with them

_____ Medication will be shipped to the JMU Health Center (additional form must be completed by student)

Provider's Signature: ____________________ Date: __________

Internal Use – Approved By:

UHC Medical Director Signature: ____________________ Date: __________