PORTER GAUD

Prescription Medication - Physician's Orders

to be completed by the legal prescriber

Permission is hereby granted to the designated employees of Porter-Gaud School to supervise my child in taking the following prescription medication.

Name of student: _____ Date of birth:_____

Grade in 2020-2021: _____

Diagnosis: _____

Name of medication: _____

Dosage: _____

Route of administration: _____

Time(s) to be administered: _____

Possible side effects of medication: _____

Expected duration of need: _____

Other medications the student is taking concurrently: _____

Allergies to medications: _____

Comments / Specific instructions: _____

☐ Please check this box if student has permission to self-administer Emergency medication at school. (Ex: Albuterol inhaler, Epi-Pen, Insulin)

_____ _____ _____

Legal Prescriber, print name/title **Signature of Legal Prescriber** **Office phone #**

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Cell phone #**

Please return to: Porter-Gaud School

Email: nurse@portergaud.edu