PHYSICIAN ORDER

PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

NAME OF STUDENT: _____DOB: _____

SCHOOL: _____GRADE: _____ TEACHER: _____

DIAGNOSIS: _____

MEDICATION; _____DOSAGE: _____

PURPOSE OF MEDICATION: _____

TIME OF DAY MEDICATION IS TO BE GIVEN: _____

POSSIBLE SIDE EFFECTS:_____

_____

ANTICIPATED NUMBER OF DAYS MEDICATION NEEDS TO BE GIVEN AT SCHOOL: _____

_____

ADDITIONAL INSTRUCTIONS:_____

_____

_____ _____

Date Signature of Physician or Health Care Provider

_____

Name of Health Care Practice

I request that school personnel administer the above medication to my child at school as ordered. As per school policy, I will deliver the medication, in an appropriately labeled container, with the name of the student, name of medication and the dosage to the school office.

_____ _____

Date Signature of parent/guardian