

PHYSICIAN ORDER**PERMISSION FOR SCHEDULED MEDICATION TO BE GIVEN AT SCHOOL**

Name of student: _____

School: _____ Grade: _____ Teacher: _____

Diagnosis: _____ Medication: _____

Dosage: _____ Time of day medication is to be given: _____

Purpose of medication: _____

Possible side effects: _____

Anticipated number of days medication to be given at school: _____

Additional instructions: _____

Date_____
Signature of Physician

I hereby give my permission for _____ to take the medication at school as ordered. I understand that it is my responsibility to furnish this medication.

Date_____
Signature of Parent or Guardian

NOTE: The medication is to be delivered to school in a container, by an adult; appropriately labeled by the pharmacy, or physician; stating the name of the student, and the name/strength/dosage of the medication.

FOR SCHOOL USE ONLY:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUG																															
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INITIALS

NAME

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NAME

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NAME

Adopted: 4-21-03

Revised: