PHYSICIAN ORDER

PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

MANHATTAN PUBLIC SCHOOLS
PO BOX 425
MANHATTAN, MT 59741
FAX: 284-6853 / PHONE: 284-3250

STUDENT'S NAME: _____

TEACHER: _____ GRADE: _____

DIAGNOSIS: _____

MEDICATION: _____ DOSAGE: _____

PURPOSE OF MEDICATION: _____

_____

TIME OF DAY MEDICATION IS TO BE GIVEN: _____

POSSIBLE SIDE EFFECTS: _____

_____

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

ADDITIONAL INSTRUCTIONS: _____

_____

_____ _____

SIGNATURE OF PHYSICIAN DATE

I hereby give my permission for _____
to take the above medication at school as odrdered. I understand that it is my responsibility to furnish this medicaiton. I authorize the release and exchange of information concerning this medication between my child's physician and the school.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

NOTE: *The prescription medication is to be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy, or physician, stating the name of the student, the name of the medication, and the dosage.*