PHYSICIAN ORDER

PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

Name of Student: ____________________________________________________________

School: ___________________________ Grade: ________ Teacher: _________________________

Diagnosis: _____________________________________________________________________

Medication: ____________________________________________Dosage: _____________________

Purpose of Medication: __________________________________________________________

Time of day medication is to be given: ______________________________________________

Possible side effects: __________________________________________________________________

Anticipated number of days to be given at school: _________________________________________

Additional Instructions: _______________________________________________________________

Date ___________________________ Signature of Physician or Healthcare Provider __________________________

Clinic Name ___________________________

Parental Consent

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

Date ___________________________ Signature of Parent or Guardian ___________________________

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.

It is the parents or guardians responsibility to PICK UP ALL MEDICATION BY THE LAST DAY OF SCHOOL or it will be disposed of.