PHYSICIAN'S ORDER
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME_____ DOB_____ GRADE_____

NAME OF DRUG_____

DOSAGE_____ TIME(S) TO BE ADMINISTERED_____

DIAGNOSIS / REASON FOR MEDICATION_____

POSSIBLE SIDE EFFECTS _____

DURATION OF USE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PLEASE PRINT OR STAMP:
PHYSICIAN'S NAME
ADDRESS
PHONE NUMBER

PARENT AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the above medication, in the original container, be administered to my child. I understand that a certified school nurse or her designated nurse substitute will be performing this service utilizing the order provided by my physician. I acknowledge that the school district and its employees and agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and / or pharmacist with any question concerning the medication.

PARENT / GUARDIAN'S SIGNATURE_____ DATE_____

HOME PHONE_____ WORK / CELL PHONE_____

INITIAL MEDICATION SUPPLY:

Name of medicine_____# of pills/tablets/capsules/ml._____

Nurse signature _____***Parent signature***_____

STUDENT'S NAME_____ DOB_____ GRADE_____

MEDICATION SUPPLY RECORD:

DATE	MEDICINE	#	PARENT SIGNATURE	NURSE SIGNATURE