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 IT NEEDS TO BE GIVEN AT SCHOOL: ______________

____

ADDITIONAL INSTRUCTIONS: ____

____

______________ ____

Date Signature of Physician

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.