PHYSICIAN'S ORDER FOR MEDICINE AT SCHOOL

In order for children to receive medicine while at school, this form must be filled out and returned to the school.

Request is for the following student: _____

Reason for medication: _____

Name of medication: _____

Dosage and mode of administration: _____

Time(s) to be given: _____

Inclusive dates during which medication is given: _____

Side effects of drug to be expected, if any: _____

Action required if side effect occur: _____

Name of Physician: _____

Physician's Phone Number: _____

Physician Signature: _____ Date: _____

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PARENT'S REQUEST FOR GIVING MEDICINE AT SCHOOL

I request that the head of school or designated staff member give my child, _____, the medicine above prescribed by

Dr. _____.

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label intact.

I understand that my signature on this form constitutes a waiver for any liability that may occur in the administering of this medicine at school when the medication is administered in accordance with the physician's direction, indicated above.

_____ Date: _____
Signature of parent or guardian

This request will expire at the end of the current school year. Please resubmit this request each school year the medication is required.

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