

**PHYSICIAN'S ORDER FOR  
ADMINISTRATION OF ORAL MEDICATION BY SCHOOL PERSONNEL**

Student's Name \_\_\_\_\_ Student's Address \_\_\_\_\_

I have prescribed the following medication for this child and request that dosage falling during school hours be administered by School personnel. (**NOTE:** Authorization is needed for non-prescription medications, also.)

Medication: \_\_\_\_\_

Condition for which prescribed: \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Instructions for use: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Frequency: \_\_\_\_\_ How Long: \_\_\_\_\_  
(number of days)

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Rx. No. \_\_\_\_\_

**PARENTAL PERMISSION**

I have delivered the above medication in the original container to the school and request that it be given to my child as prescribed.

I release \_\_\_\_\_ personnel from any liability in relation  
(name of school)  
to the administration of this medication at the center.

\_\_\_\_\_  
Date: \_\_\_\_\_ Signature of Parent or Guardian

SCHOOL STAFF: Fill in the date and time, then initial whenever dispensing medicine. (optional)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

DISPOSITION OF MEDICINE: Returned to Parents: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** Please place this form in the student's folder when medication is complete.