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.