PHYSICIAN'S ORDER FORM FOR MEDICATION

School:_____

Child's Name: _____

Address:_____

_____

Diagnosis: _____

Drug: _____ Dosage: _____

Hours to give Medication: _____

Side Effects: _____

Other Comments: _____

_____

_____

_____

_____

Signature of Physician Date

Phone Number

_____

Physician's Address

To be completed by Parent/Guardian:

I, _____, give the school nurse permission to administer the above medication during school hours. I understand that the nurse will notify me via telephone, email and/or note my child's "H" folder if the medication is administered.

Signature _____ Date _____