PHYSICIAN ORDER FOR MEDICATION

2019-20 School Year

Authorization and Permission for Administration of Medication

(Please complete one form for each medication.)

Student's Name:_____DOB: _____

Allergies: _____

Medication Name: _____

Dosage:_____Frequency:_____Route:_____Time to Administer at School: _____

Start Date:_____Duration of Order: _____

Possible Side Effects of the Medication: _____

Reason for Medication or Diagnosis: _____

X_____ ___/___/_____

(Physician Signature) (Date)

_____Telephone: _____

(Printed Name) FAX: _____