



TO BE FILLED OUT BY PHYSICIAN

Dear \_\_\_\_\_  
 Individual(s) Administering Medication

Please administer the following medication(s) to:

Name of Student \_\_\_\_\_ Address: \_\_\_\_\_

Student Telephone No. \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Diagnosis \_\_\_\_\_

Physician Medication Orders:

DAILY MEDICATIONS

Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state).

Medicine	Route	Dose	Frequency	Duration
				From: To:
				From: To:
				From: To:

PRN MEDICATIONS (as is needed)

Condition under which medication should be given

Direct contact shall be made with me should the student receiving any medication develop any of the following conditions or reactions to the medication (if none so state).

Medicine	Route	Dose	Frequency	Duration
				From: To:
				From: To:
				From: To:

I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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