

Medication Form to be filled out by the Physician

Dear _____
 (Individual[s] Administering Medication)

Please administer the following medication(s) to:

Name of Student: _____ Address: _____

Student Phone No.: _____ School: _____ Grade: _____

Diagnosis: _____

Physician Medication Orders: _____

DAILY MEDICATIONS

| Medicine | Route | Dose | Frequency | Duration | 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). |
|----------|-------|------|-----------|--------------|---|
| | | | | From: To: | |
| | | | | From: To: | |
| | | | | From: To: | |
| | | | | From: To: | |

PRN MEDICATIONS (as is needed)

| Medicine | Route | Dose | Frequency | Duration | Condition under which medication should be given. | 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). |
|----------|-------|------|-----------|--------------|---|---|
| | | | | From: To: | | |
| | | | | 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: _____