

PHYSICIAN MEDICATION ORDER FORM

•SIGNED ORIGINAL ORDER REQUIRED•

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Nonpublic School \_\_\_\_\_

\* PLEASE PROVIDE A SEPARATE FORM FOR EACH MEDICATION THAT IS TO BE ADMINISTERED.

\*PHYSICIAN TO COMPLETE:

Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Precautions/Side Effects: \_\_\_\_\_

Date \_\_\_\_\_ Physician Signature \_\_\_\_\_

(Original / No signature stamps please)

Physician Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone No. \_\_\_\_\_

\* Please note: A school nurse may not always be available during school hours to administer this medication. Please contact the school principal to determine the manner in which medication will be dispersed in the absence of a GCSSSD nurse.

\* A medication order is effective July 1 - June 30 of each school year and must be renewed annually.

I give permission for (name of student) \_\_\_\_\_

to receive medication at school as prescribed by Dr. \_\_\_\_\_

I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINAL CONTAINER, PROPERLY LABELED, AND WILL PICK UP ANY UNUSED MEDICATION. (STUDENTS ARE NOT PERMITTED TO CARRY MEDICATIONS TO OR FROM SCHOOL.)

Date

Parent/Legal Guardian Signature