PHYSICIAN'S ORDER FOR ADMINISTRATION OF ORAL MEDICATION BY SCHOOL PERSONNEL

Student's Name	Student's Address				
	edication for this child and request that dosage falling d by School personnel. (<i>NOTE</i> : Authorization is needed also.)				
Medication:					
Condition for which prescribed:					
Possible Side Effects					
Instructions for use:					
Dosage:	osage: Time:				
Frequency: How Long:					
	(number of days)				
Date: Physician	s Signature:				
Address:					
Phone:					
Pharmacy: Ph	none: Rx. No				
I have delivered the above medica that it be given to my child as pres	personnel from any liability in relation				
(name of scho to the administration of this medic	ol)				
Date:	Signature of Parent or Guardian				

SCHOOL STAFF: Fill in the date and time, then initial whenever dispensing medicine. (optional)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

DISPOSITION OF MEDICINE: Returned to Parents: _____ Date: _____

NOTE: Please place this form in the student's folder when medication is complete.