Our Lady of Perpetual Help

Physician Order for Prescription Medication and
Parent/Guardian Authorization
(TO BE RENEWED ANNUALLY)

Parent/Guardian Authorization

Date: _____

I request that my child, _____, in grade _____ be given medication during the school hours as ordered below by the physician.

I accept the rules of the school/diocese concerning the administration of medicine, including the following:

1. Medication shall be provided in an original pharmacy container with a current label. Prescription medications brought in any other container will not be administered.

2. Medication shall be brought to the office by an adult with this form completely filled out.

3. Questions regarding dosage and administration of the medication will be directed to the prescribing physician or the parent/guardian at the discretion of the school staff.

MEDICATION WILL NOT BE ADMINISTERED UNTIL ALL QUESTIONS HAVE BEEN RESOLVED.

_____ _____
Parent or Guardian Name Parent or Guardian Signature

Physician's Order

It is necessary for the medication listed below to be given during school hours:

MEDICATION NAME/STRENGTH _____
DOSAGE TO BE ADMINISTERED:_____
TIME TO BE ADMINISTERED: _____ DURATION OF ADMINISTRATION:_____
ROUTE OF ADMINISTRATION: __By Mouth __By Inhalation __Other_____

_____ _____
Physician's Name Telephone Number

_____
Physician's Signature