Parent Request and Physician's Order for Student Medication

Diocese of Raleigh

To be completed by Parent

Child's Name _____ Age _____

I request that my child be administered the medication as indicated in the physician's order below. I understand that non-medical personnel conduct the administration.

_____ _____ _____

Parent/Guardian Signature | Daytime Phone Number | Date

To be completed by Physician

The child indicated above must have the medication listed during school hours in order to function at school.

_____

Name of medication

_____ _____

Dosage | Hours to be given

_____

Method of administration

Administration by ☐ Student ☐ School Personnel

Side effects to be aware of _____

Duration of order _____ to _____

Date | Date

_____ _____ _____

Office Telephone | Physician's Name (type or print) | Physician's Signature

To be completed by School

Person Administrating Medication _____ _____

Name | Title

Approved by _____ _____

Signature of Principal | Date

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