

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL

Name of Student: _____ D.O.B. _____

Diagnosis _____

Name of Medication _____

Dosage _____

Time of Administration at School _____

Please list any specific precautions or unusual effects that may be observed.

Services should begin _____ and terminate _____

FOR INHALER OR EPI-PEN MEDICATION ONLY:

_____ It has been determined that this student is able to self-administer inhalant or Epi-pen, and has been trained in its use.

_____ This student should not self-administer inhalant medication or Epi-pen.

Physician's signature

Printed Name

Address

Phone Number

Date