Medford Area Public Schools

PHYSICIAN ORDER FOR ADMINISTRATION OF MEDICATION

Date Order Effective From: _____ To: _____

To the Nurse or Principal of: _____

Name of Student: _____ Grade: _____

Address: _____

_____

Parent/Guardian: _____ Phone: _____

Diagnosis: _____

Medication _____ Dose _____
Route _____
Frequency _____
Duration _____

Medication _____ Dose _____
Route _____
Frequency _____
Duration _____

be given: _____

_____

State the condition under which direct contact shall be made with the physician in case the student receiving the medication develops an unusual condition or reaction to the medication.

_____

_____

Physician's Signature: _____

Date: _____ Phone: _____