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 Telephone 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

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To be completed by School

Person Administering Medication _____________________________ ______________
Name Title

Approved by ____ ______________
Signature of Principal Date