ADMINISTRATION OF MEDICATION
BY THE SCHOOL NURSE
Physician's Orders

School Year September 1, 2020-August 31, 2021

(Please Print or Type)

Student's Name_____ Date of Birth_____ Grade _____
Last *First*

_____ _____ _____
Physician's Name *Address* *Phone #*

Diagnosis of illness_____

Medication_____

Route: _____ Dose:_____

Frequency: _____

Describe indications: _____

Duration of treatment: _____

List significant side effects_____

Other information regarding the administration of the medication_____

_____

Would the student be able to attend school if the medication was not administered during school hours? (yes/no) comment_____

Is the student physically fit to attend school if the above listed medication is administered at school? (yes/no) comment_____

Is the student free of contagious disease? (yes/no) comment _____

Physician's Signature _____ Date_____

Physician's Stamp