

**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 _____

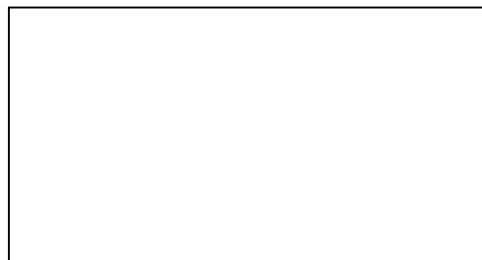
Other information regarding the administration of the medication _____

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