Physician's Order for Medication Administration

(Please type or print clearly)

Name of Student: ______________________________Birth date: __________________

School: _______________________________________ Grade: _____________________

Physician's Name: _______________________________________

Diagnosis:

____

Medication/dose:

____

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect, and oversee the administration of the medication by non-medically trained designees specified on this form, and that you will accept direct communication from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

____ ______________________

Physician's Signature Date

Comments:

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This consent is valid for the current school year.

Rev. 08/11

I GIVE PERMISSION FOR THE DOCTOR/CLINIC TO COMPLETE THIS FORM AND TO RETURN IT TO THE HEALTH OFFICE AT THE ABOVE NAMED SCHOOL.

FAX NUMBER ____

PARENT SIGNATURE ___________________________________

DATE: ____

*May the student carry the inhaler on his/her person? ______________________