

St. Charles Borromeo School

Phone: (505) 243-5788

Fax: (505)764-8842

PHYSICIAN'S ORDER & MEDICATION AUTHORIZATION FORM

Student's Name: _____ Date of Birth: _____

PHYSICIAN'S ORDER:

1. I have examined this student for (diagnosis) _____ and have determined she/he requires medication during school hours.
2. Name of Medication _____ Dosage _____
Generic substitution is permitted _____ Yes _____ No
3. Time of Administration _____
4. This student is expected to be receiving this medication (how long?)

5. Special Instructions regarding this medication

6. Contact me if the following signs and symptoms appear

Physician's Signature: _____ Date: _____
Printed Name: _____ Phone: _____

PARENT/GUARDIAN STATEMENT:

I/We, the undersigned parent(s)/guardian(s) of _____,
Request that a school employee assist the student with the self
administration of the above medication, according to the physician's
instructions. I/We agree to furnish the necessary prescribed medication in
the properly labeled container, to provide replacement of medication when
necessary, and I/We agree to notify the school immediately if the
physician or medication prescription is changed.

Parent/Guardian Signature: _____ Date: _____
Home Phone: _____ Work Phone: _____

Medication discontinued per parent: Physician notified: _____ Date: _____
Medication discontinued per Physician: _____ Date: _____