CROMWELL-WRIGHT SCHOOL MEDICATION PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM

Student's Full Name: _____

Birth Date: _____ Grade: _____

PHYSICIAN'S ORDER

I hereby request and authorize you to give:

Medication	Dosage	Time	Duration
1.			
2.			
3.			

Diagnosis/medical reason for medication: _____

Other medications this student is taking: _____

Other recommendations/UNUSUAL side effects: _____

_____

_____

Physician's Signature: _____ Date: _____

Print Physician's Name: _____ Phone: _____

Clinic Name & Address: _____ Fax: _____

PARENT/GUARDIAN AUTHORIZATION

- I request that the above medication be given during school hours as ordered by this student's physician.
- I release school personnel from any liability in relation to this request when medication is given as ordered.
- We will notify the school of any change in the medication (dosage change; discontinuation of medication before that stated above, etc.).
- I give permission for the school nurse to communicate with teachers about the action and side effects of this medication.
- I give permission for the school nurse to consult with the above-named physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
- Field trips- I give permission for the assigned teacher/responsible adult to dispense the medication on a field trip, as necessary, following school procedure.

Parent/Guardian's Signature: _____ Date: _____

Relationship to Student: _____ Phone: _____