LEROY-OSTRANDER SCHOOL
MEDICATION PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM

Name _____ Birthdate _____ 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 and address Fax #

Parent/Guardian Authorization

1. I request that the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. We will notify the school of any change in the medication (dosage change, medication is discontinued before time state in the doctor's order).
4. I give permission for the school nurse to communicate with teachers about the action and side effects of this medication.
5. I give permission for the school nurse to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication,
6. I give permission for the above-named physician to provide medication information requested by school personnel.
7. Field trips – I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Relationship to Student **Daytime phone #**