Saint Catherine of Siena School
Health Office

Medication Order for Physician and Parent

To be completed by Physician:

Is it necessary that the following medication be given during school hours Yes: ____ No: _____

Name of Student: _____ D.O.B.: _____

Medication: _____

Dosage/Route/Frequency/Time: _____

Start Date: _____ Stop Date: _____

Special Instructions/PossibleSideEffects/KnownAllergies: _____

_____

*Diagnosis: (if not confidential) _____

_____ _____
Physician's Signature Date

_____ _____
Address Telephone

To be completed by the Parent/Guardian:

Student's Name: (print) _____ DOB: _____ Grade: _____

Your Telephone: (home) _____Cell/work: _____

1. I give permission for the school nurse or her designee to administer the above named medication as prescribed
2. This medication is being taken for: _____
3. List any other medication your child takes: _____
4. Physician's Name: (please print): _____
5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.
   Yes: _____ No: _____

Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following the termination of the order.

Signature of Parent/Guardian: _____ _____
Please print Parent/Guardian Name

Date: _____