PHYSICIAN ORDER 2020 - 2021 School Year

PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

Name of student: ____

School: **Big Sky School District #72**

Teacher: ______________________________ Grade: ________________

Diagnosis: ____

Medication: ______________________ Dosage: ______________________

Purpose of Medication: ____

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Time of day medication is to be given: ______________________________

Possible side effects: ____

Anticipated number of days it needs to be given at school (provide date): ________________

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Additional instructions: ____

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Print Name of Physician: ______________________ Phone Number: ____________

Fax Number: ____________

Date: ____________ Physician's Signature: ______________________________

I hereby give my permission for (child's name) ______________________________
To take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication in it's original container. I authorize the release and exchange of information concerning this medication between my child's physician and the school.

Date: ____________ Parent Signature: ______________________________

NOTE: The **prescription medication** is to be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy or physician, stating the name of the student, the name of the medication, and the dosage.

F: WP51/files/Liz/School Nursing/SchoolNurseManual