PHYSICIAN'S ORDER FOR
ADMINISTRATION OF ORAL MEDICATION BY SCHOOL PERSONNEL

Student's Name ______________________________ Student's Address ___________________________________

I have prescribed the following medication for this child and request that dosage falling during school hours be administered by School personnel. (***NOTE***: Authorization is needed for non-prescription medications, also.)

Medication: ____

Condition for which prescribed: ____

Possible Side Effects ____

Instructions for use: ____

Dosage: ____ Time: ________________________________

Frequency: __________________________________ How Long: ___________________________________
(number of days)

Date: ____________________ Physician's Signature: ____

Address: ____

Phone: ____

Pharmacy: ___________________________ Phone: ______________________________ Rx. No. _______________

PARENTAL PERMISSION

I have delivered the above medication in the original container to the school and request that it be given to my child as prescribed.

I release REDLANDS ADVENTIST ACADEMY personnel from any liability in relation to the administration of this medication at the center.

______________________ ____

Date: Signature of Parent or Guardian

SCHOOL STAFF: Fill in the date and time, then initial whenever dispensing medicine. (optional)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

DISPOSITION OF MEDICINE: Returned to Parents: _______________________ Date: ____________

NOTE: Please place this form in the student's folder when medication is complete.