CAPITAL REGION
NURSES MIDDLE COLLEGE
CHARTER HIGH SCHOOL

PHYSICAL MEDICATION ORDER

(Student's Name) ___________________________ has been under my care for (condition or diagnosis) ______________________________________. S/he may attend school, but must take (medication) _____________________________. This medication cannot be taken effectively outside school hours. Please administer the medication in school as follows:

Time medication should be administered: ___________________________________

Dose: _____________________ Route:_________________________

Frequency of medication: _______________ Duration of medication:___________

Special Instructions: ____

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____

Physician Name Printed__________________________ Date: ___________________

Physician Signature: ____________________________ Telephone Num: ____________

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GUARDIAN'S PERMISSION

I have read and understand this form. I hereby grant permission for my child to receive the medication _____________________________ by Nurses Middle College Capital Region's school nurse as directed by his/her physician .

Parent/ Guardian Signature _________________________ Date ___________

Telephone Number: _____________________