This Portion is to be completed for all over the counter and prescription medications.

PARENT'S ORDER FOR MEDICATION

CHILD'S NAME _____

ADDRESS _____

NAME OF MEDICATION _____ DOSE _____

DATE START _____ DATE STOP _____

REASON FOR MEDICATION _____

CHILD'S PHYSICIAN _____ PHONE _____

I give my permission to the designated school personnel to give the above medication to my child according to the directions above. I agree to hold St. Ann School and the persons designated to administer the above medication harmless in any events arising from the administration of this medication. I agree to notify the school, in writing, of any change in the above orders. I further agree to keep the supply of medication replenished as needed, as I understand only a month's supply can be stored at the school.

DATE _____ SIGNATURE _____
(Parent/Guardian)

This portion to be completed by physician for Prescription Medications only.

PHYSICIAN'S ORDER FOR MEDICATION

CHILD'S NAME _____

SCHOOL _____

DIAGNOSIS _____

MEDICATION _____

INCLUDE DOSE _____ (FREQUENCY) TIMES _____

START DATE _____ STOP DATE _____

PPOSSIBLE SIDE EFFECTS _____

_____

If as needed (PRN), state condition under which medication should be given i.e. epinephrine for bee sting.

_____

_____

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by non-medically trained designees, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

DATE _____ PHYSICIAN'S NAME _____

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S TELEPHONE NUMBER _____