Parent Request and Physician’s Order for Student Medication

Diocese of Raleigh

To be completed by Parent

Child’s Name ____________________________ Age ____________

I request that my child be administered the medication as indicated in the physician’s order below. I understand that non-medical personnel conduct the administration.

______ Parent/Guardian Signature ____________ Daytime Phone Number ____________ Date ____________

To be completed by Physician

The child indicated above must have the medication listed during school hours in order to function at school.

Name of medication ____________________________

Dosage ____________________________ Hours to be given ____________________________

Method of administration

Administration by [ ] Student [ ] School Personnel

Side effects to be aware of ____________________________

Duration of order ____________________________ to ____________________________

[ ] Date [ ] Date

Office Telephone ____________________________ Physician’s Name (type or print) ____________________________

Physician’s Signature ____________________________

To be completed by School

Person Administering Medication

Name ____________________________ Title ____________________________

Approved by ____________________________ Signature of Principal ____________________________ Date ____________

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