

PHYSICIAN ORDER

Permission For Medication To Be Given At
West Yellowstone School

Name of Student:

Date Effective:

Grade:

Diagnosis:

Medication:

Dosage:

Purpose of Medication:

Time of Day Medication is to be Given:

Anticipated Number of Days it needs to be given
at School:

Possible Side Effects:

Additional Instructions:

Date:

Signature of Physician:

I hereby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. 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.