

SCOOTER SCHOOL

PHYSICIAN OR DENTIST'S ORDER

NAME OF CHILD _____ TODAY'S DATE _____

ADDRESS _____ DATE OF BIRTH _____

CONDITION FOR WHICH DRUG IS BEING ADMINISTERED DURING SCHOOL HOURS _____

DRUG: NAME, DOSE AND METHOD OF ADMINISTRATION _____

TIME OF ADMINISTRATION _____

MEDICATION SHALL BE ADMINISTERED FROM _____ TO _____
DATE DATE

RELEVANT SIDE EFFECTS TO BE OBSERVED, IF ANY _____

IF THERE ARE SIDE EFFECTS, PLAN FOR MANAGEMENT _____

IS THIS A CONTROLLED DRUG? _____ IF YES, DEA # _____

PHYSICIAN'S/ DENTIST'S NAME _____ TELEPHONE _____

ADDRESS _____

PHYSICIAN/DENTIST'S SIGNATURE _____ DATE _____

TEACHER _____ DATE _____

AUTHORIZATION BY PARENT FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL:

I HEREBY REQUEST THAT THE ABOVE MEDICATION, ORDERED BY THE PHYSICIAN/DENTIST FOR MY CHILD _____, BE ADMINISTERED BY SCHOOL PERSONNEL. I UNDERSTAND THAT I MUST SUPPLY THE SCHOOL WITH THE PRESCRIBED MEDICATION IN THE ORIGINAL CONTAINER DISPENSED AND PROPERLY LABELED BY A PHYSICIAN OR PHARMACIST.

I UNDERSTAND THAT THIS MEDICATION WILL BE DESTROYED IF IT IS NOT PICKED UP WITHIN ONE WEEK BEYOND THE END OF SCHOOL.

PARENT'S NAME _____

PARENT'S SIGNATURE _____ RELATIONSHIP TO CHILD _____

ADDRESS _____ TELEPHONE NUMBER _____