

St. Cloud Area School District 742

Doctor's Order Form

Date _____

Dear Dr. _____,

We have received medication to be administered at school for the following student, but have not received your written order for the medication. The school needs this in order to continue to administer the medication. Please fill out the following information and return promptly. Thank you for your assistance.

Student's Name _____ D.O.B. _____

Parent(s)' Name _____

Name of Medication _____

Diagnosis and Reason for Medication _____

Is it needed during school hours: Yes _____ No _____ PRN _____

Time to be administered _____

Dosage and route of administration _____

Possible side effects _____

Termination date for administration _____, or August 31 of the current school year.

The school year runs from September 1 through August 31.

I give my permission for the above-named student to receive medication at school. I am aware that medication may be administered by a paraprofessional or assistant.

Physician's Signature _____

Date _____

Return to: _____ School Nurse

_____ School

_____ Address

_____ Return FAX #