SAINT CLEMENT SCHOOL
PHYSICIAN'S ORDER FOR MEDICATION ADMINISTRATION
(Please type or print)

Date _____ Re: **Administration of Medication** to: _____

Dear Dr._____:

Pursuant to the request of the parent(s)/guardian(s): _____, Josh Jensen (Principal) and Carla Hentrich (Secretary) have been identified to administer medication to the above referenced student in the school setting. In order to proceed with the administration of the medication you have prescribed, and to ensure that you retain the power to direct, supervise, decide, inspect, and oversee the administration of this medication, please complete the following form. Direct and address this information to the individual(s) identified above. Please note that your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by the non-medically trained designees specified on this form, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in the language of the lay person. Please feel free to call if you have any questions.

_____
School Principal

---TO BE COMPLETED BY PHYSICIAN

To: _____ (Person designated to administer medication)

Name of Student _____ Phone Number _____

Address _____

School _____ Grade _____

Physician's Name _____ Phone Number _____

Physician's Address _____

Diagnosis _____

Medication/dose/route/frequency/duration _____

Medication/dose/route/frequency/duration _____

Check One: Short term _____ Long term _____

PRN (as the situation demands) Medications: _____

Medication/dose/route/frequency/duration _____

Medication/dose/route/frequency/duration _____

If a PRN medication, the conditions under which medication is to be given are as follows:

_____

Check One: Short term _____ Long term _____

The specific conditions under which contact should be made with me in relation to the condition or reactions of the student receiving the medication are as follows: _____

Physician's Signature: _____ Date: _____