BOSTON HIGASHI SCHOOL

MEDICATION ORDER

PARENT or GUARDIAN:

I request that my child _____ receive medication as prescribed in the form below.

By: _____ _____

Name of Primary Care Provider *Signature of Parent or Guardian*

Telephone Number: _____ Date: _____

Signed medication order - The written medication order form should be taken to your child's primary care provider (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be renewed as needed and at the beginning of each school year.

PHYSICIAN - I request that my patient receive the following medication:

Name of Student: _____

Diagnosis: _____

Names of Medication: _____

Prescribed Dosage: _____

Time to be taken during school hours: _____

Expected duration of treatment: _____

Possible side effects and adverse reactions: _____

_____

Other Recommendations: _____

Print Name: _____ Clinic: _____

Signature: _____ Date: _____

Telephone #: _____ Fax #: _____

E-mail: _____