MECDHH / Governor Baxter School for the Deaf
Health Center

Fax: 781-6246 Phone: 781-6251

DOCTOR'S ORDER

PERMISSION TO ADMINISTER MEDICATION IN SCHOOL

→**NOTE: USE A SEPARATE SHEET FOR EACH MEDICATION**

Student's Name ____________________________________ DOB _______________________

TO BE FILLED OUT BY PHYSICIAN:

Physician's Name (please print)____

Reason for Medication
____

Name of Medication
____

Directions (include specific area of application if topical)
____
____
____
____
____

If PRN, frequency ___________________________________Max dose in 24 hours__________

Date of Discontinue ____________________________________(Not to exceed school year)

Side effects and action to be taken ____
____
____
____

☐ Student may carry inhaler with them throughout the school day.

☐ I request and give my permission for school nurse and school personnel under the direction and at the discretion of the school nurse, to administer this medication to the above-named student.

☐ Student may self-administer this medication under the supervision of trained school personnel.

Physician's Signature ____

Physician's Tel. # __________________________________ Date________________________

TO BE SIGNED/DATED BY PARENT/GUARDIAN:

☐ Student may carry inhaler with them throughout the school day.

☐ I request and give my permission for school personnel, under the direction and at the discretion of the school nurse, to administer this medication to the above-named student.

☐ Student may self-administer this medication under the supervision of trained school personnel.

Parent/Guardian Signature _____________________________________Date ______________