Presentation BVM School
105 Old Soldiers Rd.
Cheltenham, PA 19012
www.presentationbvmschool.org (215) 379-3798

Medication Administration Physician Order & Parental Consent

Name of Student: _____ Date of Birth: _____ Grade:_____

Prescription Medication Treatment Plan
To Be Completed by Physician

Diagnosis:

_____

_____

Medication, Dosage, Specific Times & Direction for Administration:
(Please write each medication, dosage, frequency and time separately)

_____

_____

Side Effects/Special Instructions:

_____

_____

*Note to Physicians: Please include directions for students who require any special health procedures during school hours; i.e., inhalers, nebulizer treatments, catheterization, suctioning, tube feedings, glucose testing, etc.

_____ _____ _____
Printed Name or Stamp of Physician Physician's Signature Date

_____ _____
Physician's Phone Number Physician's Fax Number

Over the Counter Medication (eg. Tylenol, Motrin etc)
To Be Completed by Parent

Medication, Dosage and Direction for Administration:

_____

_____

I grant the administrator and/or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day

_____
(Signature of Parent(s)/Guardian(s) Date

Primary Phone Number: _____ Work Phone Number_____