SCHOOL DISTRICT OF CLEAR LAKE

Physician Order for Medication Administration

Date order effective from:_____ to_____

Name of Student _____

Address of student _____

_____

Telephone Number _____

School _____ Grade_____

Diagnosis or reason for medication_____

_____

Medication_____

Dose/Site: (see attached protocol)_____

Time Medication to be given:_____

Any additional orders or comments:_____

_____

Specific conditions under which contact should be made with you:_____

_____

Physician's Name_____

Physician's Address_____

_____

Physician's Telephone #_____

Physician's Signature_____

Date_____