

FALSE RIVER ACADEMY
PHYSICAN ORDER

This form enables the Principal or his/her designee to dispense medication.

Student: _____ DOB _____

Medication Name: _____

Dose/Route _____

Time of administration: _____

Diagnosis: _____

Potential Adverse Effects: _____

Is it necessary that student take medication on the Field Trip: ___ Yes ___ No

To be completed by MD- Use this space ONLY for students who will self administer their asthma inhaler, epinephrine, or insulin:

Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school? _____ Yes _____ No

Student may carry necessary item on his/her person. _____ Yes _____ No

Additional Comments:

My signature enables the parent to give the Principal, or his/her designee, authority to dispense and observe the partaking of prescribed medication.

Physician's Name (Printed)

Physician's Signature/Date