PHYSICIAN ORDER 2023 - 2024 School Year

PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

Name of student: _____________________________________________________________

School:  Big Sky School District #72

Teacher: _____________________________________________ Grade: ___________________

Diagnosis: ___________________________________________________________________

Medication: ___________________________ Dosage: _____________________________

Purpose of Medication: _______________________________________________________

____________________________________________________________________________

Time of day medication is to be given: ___________________________________________

Possible side effects: _________________________________________________________

Anticipated number of days it needs to be given at school (provide date): ______________

____________________________________________________________________________

Additional instructions: _______________________________________________________

____________________________________________________________________________

Print Name of Physician: ________________________ Phone Number: ________________

Fax Number: _________________

Date: ___________________ Physician’s Signature: __________________________________

I hereby give my permission for (child’s name) _____________________________________
To take the above medication at school as ordered. I understand that it is my responsibility to furnish this
medication in it’s original container. I authorize the release and exchange of information concerning this
medication between my child’s physician and the school.

Date: ___________________ Parent Signature: _________________________________

NOTE: The prescription medication is to be brought to school by the parent or guardian in a container
appropriately labeled by the pharmacy or physician, stating the name of the student, the name of the
medication, and the dosage.