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.