Medical Provider Permission

Student's Name: _____ **Date of Birth:** _____ **Grade:** ____

Diagnosis: 1. _____ **2.** _____

I am prescribing the following medication and procedures for the above student to be administered or performed at school.

DAILY

Name of Daily Medication (Generic and Trade Name)	Dosage and Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

PRN

Name of PRN Medication (Generic and Trade Name)	Dosage and Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

PROCEDURES

Name of Procedure (Catheterization, glucose checks, suctioning, etc.):	Dosage and Frequency	Time(s) (AM/PM):	Start date	Stop date	Monitoring Parameters

The above orders shall be effective throughout the current school year, summer school and through September 30th of the following next school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.

_____ _____ _____

Medical Provider's Signature | Date (Mo./Day/Yr.) | Telephone/Fax Number

_____ _____

Printed Medical Provider's Name | Address