## Parent Request and Physician's Order for Student Medication

## **Diocese of Raleigh**

To be completed by	Parent	
Child's Name		Age
	d be administered the medication as indicat nedical personnel conduct the administratio	
Parent/Guardian Sig	nature Daytime Phone Number	Date
To be completed by	Physician	
The child indicated al school.	pove must have the medication listed during	g school hours in order to function at
Name of medication		
Dosage	Hours to be	given
Method of administration		
Administration by	Student School Personnel	
Side effects to be awa	are of	
Duration of order	to	
	Date	Date
Office Telephone	Physician's Name (type or print)	Physician's Signature
To be completed by	School	
Person Administratin	a Medication	
	Name	Title
Approved by	Signature of Principal	Date
	Signature of Frincipal	Date
June 02		A5506.1