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Mary Robinson Cohen, M.A., J.D.
Superintendent and Principal

MEDICATION ADMINISTRATION ORDER/PERMISSION FORM

Student's Name ______________________________

Date of Birth ______________________________

Diagnosis ______________________________

Name of Drug/Medication ______________________________

Dosage to be given ______________________________

Time to be given ______________________________

Purpose of Medication ______________________________

Duration of therapy ______________________________

Anticipated Adverse Reactions ______________________________

I/We give permission for the above drug/medication to be administered to this student by the school nurse.

Physician's Signature ______________________________ Date ______________

Physician's Name (Please print) ______________________________

Address ______________________________

Phone # ______________________________

Parent's Signature ______________________________ Date ______________

Reviewed by School Nurse ______________________________ Date ______________