Physician Order

To: St. John the Baptist School
Please administer the following medication:
Name of Student: ____
Name of Medication: ____
Dosage: ____
Time Interval: ____
Diagnosis/Reason for Medication: ____
Check if Applicable: ____This medication is for a chronic problem; this statement applies as needed during the 20__ - 20__ school year.

Date: __________________ Physician's Signature: __________________________

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Parent Request

To: St. John the Baptist School
Please comply with the written order of Dr. _________________________________
To administer the prescribed medication to my child, _________________________.
Date: __________________ Parent's Signature: _____________________________

Physician Order

To: St. John the Baptist School
Please administer the following medication:
Name of Student: ____
Name of Medication: ____
Dosage: ____
Time Interval: ____
Diagnosis/Reason for Medication: ____
Check if Applicable: ____This medication is for a chronic problem; this statement applies as needed during the 20__ - 20__ school year.

Date: __________________ Physician's Signature: __________________________

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Parent Request

To: St. John the Baptist School
Please comply with the written order of Dr. _________________________________
To administer the prescribed medication to my child, _________________________.
Date: __________________ Parent's Signature: _____________________________