LOYALSOCK TOWNSHIP SCHOOL DISTRICT

PRESCRIPTION MEDICATION FORM

Date:_____ Name of Student:_____

Address:_____

Medication	Strength	Dosage	Time to be Given	Route of Administration	Duration of Order

Purpose of Medication:_____

Side Effects:_____

Comments:_____

Please Print/Type Physician's Name/Address/Phone:

_____

_____

_____

_____

_____ _____

Physician's Signature Date