LOYALSOCK TOWNSHIP SCHOOL DISTRICT
MEDICATION FORM

Physician's Order For Prescription Medication

Name of Student _____

Date of Birth _____

Medication Dosage Time to Be Given Route of Administration Duration of Order

_____

_____

_____

Purpose of Medication:

_____

_____

Side Effects:

_____

_____

_____

Comments:

_____

A written physician's order is required to change or discontinue a medication.

_____

_____ _____

Physician's Signature Date

_____ _____

Physician's Name-PRINTED Telephone Number

_____

Fax Number