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