POINT PLEASANT SCHOOLS

Part I - To be completed by the physician

I certify that it is essential to the health of _____
that the following medication be administered during school hours as directed:

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Mode of administration: _____

If medication is given prn, describe indications: _____

How soon can it be repeated? _____

Significant side effects include: _____

Length of time this order is valid (may NOT exceed school year) _____

Physician's signature: _____ Date: _____

Physician's stamp:

Part II - To be completed by the student's parent/guardian

I hereby request that the school nurse administer the above medication as directed by my physician to my child. I will supply the medication in ORIGINAL CONTAINER from the pharmacy. An adult will deliver the medication to the school. I will notify· the school nurse promptly of any changes.

Signature of Parent/Guardian	Date
Child's Name	Grade
Print name of physician	Physician's telephone number

Incomplete forms will not be accepted.

PPHS	Memorial School	Nellie Bennett	Ocean Road
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ext.2215	ext.2303	ext.5209	ext.4122