MARTINS FERRY CITY SCHOOL DISTRICT

Medication Orders from Physician

It is necessary that _____ have medication during school hours.
(pupil's name)

He/She must take:

Medication	Dosage	Time	Duration
_____	_____	_____	_____

Possible reactions to be reported to physician: _____

_____

_____ _____
Physician's Signature Phone

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I, the parent/guardian of _____ give permission for the medication ordered by the above physician to be given at school.

I further agree to:

1. Deliver the medication to school in the original pharmacy bottle labeled by the pharmacist with the Name of the medication, the amount to be given, time of the day to be taken, the Physician's name and the expected duration of treatment.

2. Notify the school if I change physicians.

3. Notify the school if the medication or dosage is changed or eliminated.

_____ _____ _____
Parent Guardian Signature Phone Date

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_____
Nurse