NORRISTOWN AREA SCHOOL DISTRICT

Administration Building
401 N. Whitehall Rd.
Norristown, PA 19403

MEDICATION ADMINISTRATION IN SCHOOL

(*Please use one sheet per medication*)

PHYSICIAN'S ORDER

STUDENT NAME: _____ **BIRTHDATE:** _____

DIAGNOSIS: _____

MEDICATION: _____

ROUTE: _____

DOSE TO BE GIVEN:

_____**on Arrival**

_____**at Lunch**

_____**at other time**

_____ _____
Physician's Signature **Date**

_____ _____
Please Print Physician's Name **Physician's Phone Number**

_____
Address

_____
City **State** **Zip**

Parent/Guardian Permission

☐I give permission for my child to receive medication in school.

☐ I give permission for communication between the school nurse and the prescribing health care provider/pharmacy regarding this medication.

Parent/Guardian Signature **Date**

SN 13
5/2020