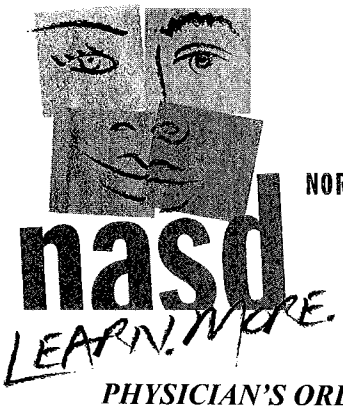

NORRISTOWN AREA SCHOOL DISTRICT

MEDICATION ADMINISTRATION

(Please use one sheet per medication)

PHYSICIAN'S ORDER

Student: _____ Birthdate: _____

Diagnosis: _____

Medication: _____

Route: _____

Dose to be given: _____ ***on arrival***

Dose to be given: _____ ***at lunchtime***

Dose to be given: _____ ***at other times***

Side Effects: _____

_____

Physician's Signature Date

_____ _____

Please Print Physician's Name Physician's Telephone Number

_____

Address

_____

Town State Zip

PARENT/GUARDIAN PERMISSION

I give permission for _____ to receive medication in school.

Name of Student

_____

Parent/Guardian Signature Date

Please notify the school nurse in writing, if medication is discontinued.

SN-81 2/05