MARTINS FERRY CITY SCHOOL DISTRICT

5001 AYERS LIMESTIONE ROAD
MARTINS FERRY, OH 43935
PHONE: (740) 633-1732
FAX: (740) 633-5666

Medication Orders from Physician

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

He/She must take:

Medication	Dosage	Time	Duration

Possible reactions to be reported to physician:

_____

Physician's Signature: _____Phone: _____

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: _____

Nurse: _____ Date: _____