

**BISHOP FEEHAN HIGH SCHOOL-PHYSICIAN ORDER**

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis\* \_\_\_\_\_

Other medical conditions\*/allergies \_\_\_\_\_  
\_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Route \_\_\_\_\_  
Frequency \_\_\_\_\_

**(Please note that whenever possible medications should be scheduled at times other than school.)**

Date of order \_\_\_\_\_ Discontinuation date \_\_\_\_\_

**Optional Information**

- 1. Side effects, contraindications, adverse reactions \_\_\_\_\_
- 2. Other medication taken by student \_\_\_\_\_
- 3. Date of next scheduled visit \_\_\_\_\_
- 4. Consent for self administration (provided school nurse determines it is safe and appropriate).  
Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ Signature of Licensed Prescriber

\_\_\_\_\_ Printed Name of Same

\_\_\_\_\_ Business/Emergency Telephone #

\*If not a violation of confidentiality

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**Written Parent/Guardian Consent for Medication Administration**

I give permission to the school nurse to give the following medication \_\_\_\_\_  
prescribed by \_\_\_\_\_ to my child \_\_\_\_\_

I give permission for my child to self administer medication if the school nurse  
determines it is safe and appropriate. Yes \_\_\_\_\_ No \_\_\_\_\_

I give permission to the school nurse to share with school personnel information about  
this medication as determined necessary for my child's safety and health. Yes \_\_\_ No \_\_\_

Date \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

Relationship to student \_\_\_\_\_

Known allergies \_\_\_\_\_ Emergency #'s \_\_\_\_\_