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 hours.)
Date of order ________________ Discontinuation date ________________
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 (name) ____

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.

Date _____________
Signature of parent/guardian _____________________________
Relationship to student _________________________________
Known allergies ____
Emergency #'s ___________________________

*****Please note that any prescription medications must be picked-up at the close of the last day of school. Any prescription medication left beyond that time will be disposed of. Prescription medications are not kept over the summer vacation.