Newburg R-II School District
Physician Order Form

Date form received by the school ____/____/____

Student's Name: _____ Date of Birth: _____

To Be Completed By Physician:

Name of Medication: _____ Form: _____

Reason for Medication: _____

Instructions (schedule and dose to be given at school): _____
_____

Start Date: _____ Stop Date: _____

☐ For episodic/emergency events only

Restrictions and/or important side effects: _____
_____

☐ I have attached a treatment plan for managing student's condition.

☐ I have instructed student in the correct and responsible use of medication.

☐ Student has demonstrated to me or my designee the skill level necessary to self-administer medication according to treatment plan.

☐ This student both capable and responsible for self-administering this medication according to treatment plan.

- ☐ Yes- supervised
- ☐ Yes- unsupervised

This student may carry this medication ☐ Yes ☐ No

Physician's Signature: _____Date: _____

Physician's Name (please print): _____

Address: _____ _____ Phone: _____

To be completed by Parent/Guardian:

I hereby give permission for my child, _____, to receive the above medication at school according to the school policy. I release the school district from any responsibility of my child's misuse or inappropriate use of medication.

Parent/Guardian's Signature: _____ Date: _____

Medications should be brought in original containers only.