St. Mary Magdalene
CATHOLIC SCHOOL

Physician Order for Student Medication

To be completed by parent

Child's name:_____ Age:_____ Grade: _____

I request that my child be administered the medication as indicated in the physician's order below. I understand that non-medical personnel may administer the medication. I understand that the school undertakes no responsibility for the administration of the medication and I hereby release St. Mary Magdalene School and its agents and employees from any and all liability that may result from my child taking the medication listed.

_____ _____ _____

Parent/Guardian Signature *Daytime Telephone* *Date*

To be completed by Physician

The child indicated above may have the medication listed during school hours.

Medication	Route	Dosage	Schedule	Side Effects

*Duration of order*_____*to*_____
Date *Date*

_____ _____ _____
Physician's Signature *Physician's Name (type or print)* *Office Telephone*