

PHYSICIAN ORDER FOR PRESCRIBED MEDICATIONS

Doctor, please complete and sign the following medication order(s) for any medications that the indicated student will be taking during the school year at Darrow School. Please send updated copies with any dose or medication change.

STUDENT: _____

D.O.B.: _____ ALLERGIES: _____

PRESCRIBING PHYSICIAN (please print name here): _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Please feel free to contact Darrow School Health Services with any questions or concerns.

Darrow School, 110 Darrow Road, New Lebanon, NY 12125

Telephone: (518) 794-6013

Fax: (518) 794-6024