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 The 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.

The Darrow School, 110 Darrow Road, New Lebanon, NY 12125
Telephone: (518) 794-6013
Fax: (518) 794-6024