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) 704-2739
Fax: (518) 794-6024