Medication Instructions from Prescribing Doctor

Prescribing Doctor to Complete

To be confidentially stored until the student is 25 years of age.

These instructions are required in order for the school to maintain its 'duty of care', administering prescribed drugs to a student whose condition would otherwise preclude attendance at school.

Dr ____________________

Address: ____________________

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Telephone: ____________________

I have prescribed the drug________________________for______________________
(Name of Student)

to treat the condition of ____________________________
(Condition)

This drug needs to be administered ____
(Dose) (Frequency/Time)

Are special arrangements necessary to administer the drug or monitor the student after drug administration? Yes ( ) No ( )

If so, please provide details below:

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________________________________ Date: _______________
Signature of Prescribing Doctor

________________________________ Date: _______________
Principal's Signature