

MOUNT AVIAT ACADEMY
399 Childs Road
Childs, Maryland 21916
410-398-2206
FAX 410-398-8063

PHYSICIAN'S MEDICATION ORDER
(to be completed by physician ordering medication)

Name of Student: _____

Reason for Medication: _____

Medication: _____

Dosage: _____

Route: _____ Time: _____

Possible side effects/Procedures to be followed: _____

Significant Information/Special Instructions: _____

Physician's Signature: _____

Date: _____ Phone: _____

Parent Authorization

I authorize the school to give the above medication to my child. I relieve the school and its employees of any liability for damages as a result of any adverse drug reaction suffered by the student as a result of administering or failure to administer said medication. I understand it is my responsibility to supply medication in the original labeled container with one week's supply of medication.

Parent's /Guardian's Signature

Date: _____ Phone: _____