Prescription Medication - Physician's Orders

to be completed by the legal prescriber

Permission is hereby granted to the designated employees of Porter-Gaud School to supervise my child in taking the following prescription medication.

Name of student: ____ Date of birth:___________

Grade in 2024-2025: _________

Diagnosis: ____

Name of medication: ____

Dosage: ____

Route of administration: ____

Time(s) to be administered: ____

Possible side effects of medication: ____

Expected duration of need: ____

Other medications the student is taking concurrently: _____________________________

Allergies to medications: ____

Comments / Specific instructions: ____

☐ Please check this box if student has permission to self-administer Emergency medication at school. (Ex: Albuterol inhaler, Epi-Pen, Insulin)

________________________________	___________________________	_____________
Legal Prescriber, print name/title	**Signature of Legal Prescriber**	**Office phone #**
________________________________	_______________	________________
Signature of Parent/Legal Guardian	**Date**	**Cell phone #**

Please return to: Porter-Gaud School

Email: nurse@portergaud.edu