

Holy Spirit High School  
500 South New Road  
Absecon, NJ 08201  
(609) 646-3000

PHYSICIAN MEDICATION ORDER FORM  
•SIGNED ORIGINAL ORDER REQUIRED•

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Nonpublic School \_\_\_\_\_

**\* PLEASE PROVIDE A SEPARATE FORM FOR EACH MEDICATION THAT IS TO BE ADMINISTERED.**

**\*PHYSICIAN TO COMPLETE:**

Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Precautions/Side Effects: \_\_\_\_\_

Date \_\_\_\_\_ Physician Signature \_\_\_\_\_

(Original/No signature stamps please)

Physician Name _____
Address _____
Telephone No. _____

**\* Please note: A school nurse may not always be available during school hours to administer this medication. Contact the school office to obtain times and days the nurse is assigned.**

**\* A medication order is effective July 1 - June 30 of each school year and must be renewed annually.**

I give permission for (name of student) \_\_\_\_\_

to receive medication at school as prescribed by Dr. \_\_\_\_\_

**I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINAL CONTAINER, PROPERLY LABELED AND WILL PICK UP ANY UNUSED MEDICATION.**

\_\_\_\_\_  
Date Parent/Legal Guardian Signature