DINWIDDIE COUNTY Public Schools

PHYSICIAN'S INSTRUCTIONS FOR ADMINISTRATION OF MEDICATION IN THE SCHOOL (PRESCRIPTION AND NON-PRESCRIPTION)

I. COMPLETED BY PARENT

Date: ____________________

A. Full Name of Child: ____
Please Print

Date of Birth: ____
Month *Day* *Year*

NOTE TO PHYSICIAN:

B. Permission is hereby given for the release of the information requested below to the Dinwiddie Public Schools. The completed form should be sent to:

Name of School: ____

Address: ____

____

Parent/Guardian Signature: ____

II. COMPLETED BY PHYSICIAN: *(Please Print)*

Date: ____________________

A. Is it imperative that medication be administered to this child during the school day in order for him/her to participate in the school program?

__________ Yes __________ No

B. Identification and Administration:

NAME OF MEDICATION(S)	DOSAGE (AMT)	TIME	DURATION

C. Special precautions or reactions for which the physician should be contacted:

____

____

D. Physician's Signature: ____________________ Date:____________________

FORM NO.: MED 2

REV 08/2016