Arcadia Charter School
1719 Cannon Road
Northfield, MN 55057
Phone 507-663-8806
Fax 507-663-8802

Name of Student _____ **DOB**_____

School_____ **Date**_____

PHYSICIAN'S ORDER:
I hereby request and authorize the school to give:

Medication	**Dosage**	**Time given**	**Duration**

Diagnosis/ICD-10 Code/Medical Reason:_____
Other medications this student is taking:_____
Side effects:_____
Physician signature:_____ **Date**_____
Physician printed name:_____ **Phone #**_____
Clinic name & address_____ **Fax#**_____

PARENT/GUARDIAN AUTHORIZATION:

- I request that the above medication be administered during school hours as ordered byy this student's physician.
- I release school personnel from liability in relation to this request when the medication is given as ordered.
- We will notify the school of any change in the medication (dosage, discontinuation of the medication before the stated time on the Dr. order.)
- I give permission for the school nurse to communicate with teachers/staff about the action and side effects of this medication.
- I give permission for the school nurse to consult with the named physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
- **FIELD TRIPS:** I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

Signature of Parent/Guardian_____Date_____

Relationship to student_____Phone#_____