



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 by 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# _____