Verona Area School District

Physician Order for Medication

Please administer the following medication(s) to:

Name of Student	School
Diagnosis	Date of Birth
Name of Physician ordering medication or procedure	Phone number of physician
	Fax number of physician

Medications Medicine	Route	Dose	Frequency	Duration	Potential side effects that should be reported
				From: To:	
				From: To:	
				From: To:	
				From: To:	
				From: To:	

Hospital/Clinic/Office	Phone Number
Address: Street, City, State, Zip	
Physician's Signature	Date
Comments:	

RETURN THIS FORM TO THE SCHOOL NURSE