GARLAND INDEPENDENT SCHOOL DISTRICT
Health Services

Physician's Order for Over-the-Counter/Sample Medication

School Name: _____ Phone #: _____

Address: _____ Fax #: _____

Physician's Order for Over-the-Counter/Sample Medication

Student's Name: _____ DOB: _____

Name of Medication: _____
(specific formulation i.e. Acetaminophen E. S.)

Dosage: _____ Route of Administration: _____
(specific – mgms not # tabs)

Frequency: _____ Duration: _____
(must be specific -- as needed not acceptable) (maximum time is current school year)

Indication: _____
(must be specific – i.e. for severe headache . . . . . for pain not acceptable)

Name of Medication: _____
(specific formulation i.e. Acetaminophen E. S.)

Dosage: _____ Route of Administration: _____
(specific – mgms not # tabs)

Frequency: _____ Duration: _____
(must be specific -- as needed not acceptable) (maximum time is current school year)

Indication: _____
(must be specific – i.e. for severe headache . . . . . for pain not acceptable)

_____ _____
Date Physician's Signature

_____ _____
Physician's Telephone Number Physician's Fax Number

For more detailed information about medications taken during the school day, refer to the Student Handbook or Board Policy FFAC.

Parent's Permission for Over-the-Counter/Sample Medication

Disposal of unused medication: _____ Parent will pick up or
_____ Student may return medication home

I hereby give my permission for my son/daughter to take the medication as ordered above during the school day.

_____ _____
Date Parent's Signature

For OFFICE use only: ☐Med entered in EMR ☐Scanned and uploaded ☐Updated Health Condition ☐Update/create IHP