DESOTO 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: _____ ID#: _____

Name of Medication: _____
(specific formulation i.e. Acetaminophen extra strength)

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

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

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

_____ _____
Date Physician's Signature

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

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

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

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

_____ _____
Date Parent's Signature