GARLAND INDEPENDENT SCHOOL DISTRICT

Health Services

Physician's Order for Medication

Student's Name: _____ DOB: _____

School Year: _____ Student ID#: _____

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

Dosage: _____ Route of Administration: _____
(mg or mL – no ranges)

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)

Dosage: _____ Route of Administration: _____
(mg or mL – no ranges)

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**)

_____ _____
Printed/Stamped Name of Physician Physician's Signature

_____ _____ _____
Date Physician's Phone Number Physician's Fax Number

Note: Adjustment of the medication or discontinuation requires a written, signed physician's order. The Nurse Practice Act of Texas requires clarification of any order that the nurse has reason to believe is inaccurate, non-efficacious, or contraindicated by consulting with the appropriate licensed practitioner.

** To Be Completed by Parent **

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

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

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

_____ _____
Signature of Parent/Guardian Date

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