

**St. Francis Xavier School
234 Pleasant St
South Weymouth, MA 02190
781-335-6868**

**Medication Order for School Year 2009-2010
(Please complete one form per medication)**

(Section 1 to be completed by Parent of Guardian)

Name of Student: _____ DOB: _____ Grade: _____

Address: _____ Town: _____

I request that the medications authorized on this form, ordered by the physician for my child, be administered by designated school personnel. I understand that all medications must be supplied to St. Francis Xavier School in the original labeled pharmacy container. This includes over-the-counter and prescription medications.

Parent Name: _____ Date: _____

(Section 2 to be completed by Student's Physician)

Name of Licensed Provider: _____ Title: _____

Physician's Address: _____ Telephone: _____

(Please note: whenever possible, medications should be scheduled at times other than school hours.)

Diagnosis for which medication is prescribed: _____

Medication: _____

Route: _____ Dosage: _____

Frequency: _____ Times of Administration: _____

Length of time treatment is recommended: _____

Allergies: _____

Special side effects, contraindications, or possible adverse reactions to be observed: _____

Any other medical condition: _____

Physician's signature: _____

Date: _____