Waterford-Halfmoon School District
125 Middletown Road
Waterford, New York 12188

PHYSICIAN'S ORDER FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

______________________________ has been under my care for

____
Diagnosis

He / she is now able to return to school but must take:
____________________________________ as follows
____________________________________ during school hours.

______________________ ______________________
Date Doctor's Signature

SIDE EFFECTS____

PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION

____
Date

I/we hereby request that the medication ordered by our physician as indicated above be administered as ordered to our child.

_________________________________ __________________
Child's Name Grade

____
Parent's Signature

____
Parent's Signature