

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

**Medication Order for School Year 2010-2011  
(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: \_\_\_\_\_