



# THIS SIDE FOR LONG-TERM MEDICATIONS

## Physician Request and Authorization

Archdiocese of Atlanta

Name of School: \_\_\_\_\_  
 Address of School: \_\_\_\_\_  
 Telephone No. of School: \_\_\_\_\_  
 Name of Student: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Student Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_

<b>Physician Medication Orders: Daily Medications</b>					Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medications (if none, so state):
Medicine	Route	Dose	Frequency	Duration	
				From: To:	
				From: To:	
				From: To:	

<b>PRN Medications (as is needed)</b>					Condition under which medication should be given:	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medications (if none, so state):
Medicine	Route	Dose	Frequency	Duration		
				From: To:		
				From: To:		
				From: To:		

I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medications(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_