

Saint Raymond Catholic School
7940 Williams Ave.
Philadelphia, PA 19150

Name of Student: _____ Date of Birth: _____ Grade: _____

School: _____ Fax #: _____ Phone #: _____

Medication Treatment Plan
To Be Completed by Physician

Diagnosis:

Medication, Dosage, Specific Times & Director for Administration:

(Please write each medication, dosage, frequency and time separately) _____

NOTE: Medication must be supplied in the original prescription container. Ask pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/Special Instructions:

*Note to Physicians: Please complete the treatment plan on the back of this form for students who require any special health procedures during school hours; i.e., inhalers, nebulizer treatments, catheterization, suctioning, tube feedings, glucose testing, etc.

Printed Name or Stamp of Physician

Physician's Signature

Date

Physician's Phone Number

Physician's Fax Number

Parental Permission

To Be Completed by Parent(s)/Guardian(s)

I grant the administrator or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when _____ is away from school property on official school business.

(Name of Student)

(Signature of Parent(s)/Guardian(s))

(Date)

Home Phone Number: _____ Work Phone Number: _____