



## Prescription Medication - Physician's Orders

*to be completed by the legal prescriber*

Permission is hereby granted to the designated employees of Porter-Gaud School to supervise my child in taking the following prescription medication.

Name of student: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Grade in 2026-2027: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Route of administration: \_\_\_\_\_

Time(s) to be administered: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_

Expected duration of need: \_\_\_\_\_

Other medications the student is taking concurrently: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Comments / Specific instructions: \_\_\_\_\_

Please check this box if student has permission to self-administer Emergency medication at school. (Ex: Albuterol inhaler, Epi-Pen, Insulin)

\_\_\_\_\_  
Legal Prescriber, print name/title

\_\_\_\_\_  
Signature of Legal Prescriber

\_\_\_\_\_  
Office phone #

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Cell phone #

Please return to: Porter-Gaud School

Email: [nurse@portergaud.edu](mailto:nurse@portergaud.edu)