2018–2019 Physician Medication Order
To be completed by a licensed prescriber

Child's Name: _____
DOB: _____
Grade: _____
Weight: _____

Licensed Prescriber: _____
Title: _____
Telephone #: _____

Medication: _____
Route of Administration: _____
Dosage: _____
Frequency: _____
Time of Administration: _____
Instructions or Information: _____
Date of Order: _____
Discontinuation Date: _____
Diagnosis: _____

Signature of Lic. Provider: _____
Date: _____