DESOTO INDEPENDENT SCHOOL DISTRICT
Health Services

Physician’s Order for Over-the-Counter/Sample Medication

School Name: ______________________________ Phone #: __________________
Address: ______________________________ Fax #: __________________

Physician’s Order for Over-the-Counter/Sample Medication

Student’s Name: ____________________________________________________________________ DOB: ___________ ID#: ___________

Name of Medication: ___________________________________________________________________
(specific formulation i.e. Acetaminophen extra strength)

Dosage: ______________________________ Route of Administration: ____________________________
(be specific – not # tabs)

Frequency: ______________________________ Duration: ____________________________
(be specific – as needed not acceptable) (maximum time is current school year)

Indication __________________________________________________________________________
(must be specific – i.e. for migraine headache – for pain not acceptable)

___________________________ __________________________
Date Physician’s Signature

___________________________ __________________________
Physician’s Telephone Number Physician’s Fax Number

Parent’s Permission for Over-the-Counter/Sample Medication

Disposal of unused medication: ______ Parent will pick up
_______ Student may return medication home

I hereby give my permission for my son/daughter to take medication as ordered above during
the school day.

___________________________ __________________________
Date Parent’s Signature

06/2022