GONZALES INDEPENDENT SCHOOL DISTRICT
MEDICAL ORDERS FOR HEALTH SERVICES AND PROCEDURES
MEDICATIONS INCLUDING NEBULIZER AND OXYGEN THERAPY

Date: _____

Dear Dr: _____

Student Name: _____ DOB: _____

The policy of Gonzales Independent School District regarding the matter of administering medication(s)/special procedure(s) at school is that the medication(s)/special procedure(s) shall be administered only when the student's health requires that they be given during school hours. Written authorization from the student's parents/guardians and physician is required for the long-term (more than 2 weeks) use of medication(s)/procedure(s). Medication(s) that are administered at school must be in a properly labeled prescription container

Nurse: _____

School: _____

Address: _____

Telephone: _____ Fax: _____

The following portion of this form should be completed by the student's physician and returned to the above-noted school:

This student is to receive _____by _____
(Medication & Dosage/Procedure) (Route)

at _____ for the treatment of _____.
(Time) (Diagnosis Requiring Medication/Procedure-Required)

Possible Side Effects: _____.

Estimated termination date: _____.

_____ _____
Physician's Signature Date

_____ _____
Physician's Name Printed Telephone Number

I hereby give my permission for my child to receive the above-mentioned medication/special health procedure at school as prescribed by my child's physician. The school, for physician evaluation, may do medication evaluation forms periodically.

_____ _____
Parent/Guardian's Signature Date

NOTE: Medication must be supplied in a properly labeled prescription container. Ask your pharmacist to divide the medication into two (2) properly labeled container-one for home and one for school.