PHYSICIAN REQUEST AND AUTHORIZATION

Name of School: ____St. John Vianney School__________________________
Address of School: ____17500 West Gebhardt Road, Brookfield, WI 53045
Telephone # of School: ____262-796-3942______________________________

Name of Student: ________________________ Address__________________________
Home phone #: __________________ Student Age: _______________ Grade: ____
Diagnosis: ____
PHYSICIAN MEDICATION ORDERS:

Daily Medications

Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medications

Medicine	Route	Dose	Frequency	Duration