DCS

DADE CHRISTIAN SCHOOL

"Where Christ Makes The Difference"

Treatment Plan (To be completed by Physician)

Student's Name _____

Diagnosis_____

Medication and dosage prescribed _____

_____

Instructions for Administration _____

_____

Name of Physician (Print)_____

Physician Signature_____

Office Number_____

Date: _____

Parental Permission (To be completed by Parent or Guardian)

My permission is given, for designated Clinic personnel, to administer the above prescribed medication to my child.

Name of Student_____

Name of Parent/Guardian_____

Signature _____

Phone Number_____