

**St. Philip Neri School**  
**Phone: 215-679-7481**  
**Fax: 215-679-8370**  
**2009-2010 School Year**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

---

Medication Treatment Plan to be completed by Physician:

Diagnosis: \_\_\_\_\_

Medication, dosage, Specific Time & Director for Administration (Write each medication, dosage, frequency, and time separately): \_\_\_\_\_

---

**NOTE: Medication must be supplied in the original prescription container.** Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side effects/Special Instructions: \_\_\_\_\_

---

\*Note to Physicians: Please complete the treatment plan on the back of this form for students who require any special health procedures during school hours, i.e., inhalers, nebulizers treatments, catheterization, suctioning, tube feedings, glucose testing, etc.

\_\_\_\_\_  
Printed Name or Stamp of Physician      Physician's Signature      Date

\_\_\_\_\_  
Physician's Phone Number      Physician's Fax Number

---

Parental Permission to be completed by Parents(s)/Guardian(s).

I grant the administrator or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when \_\_\_\_\_ is away from school property on official school business.

(Name of student)

\_\_\_\_\_  
(Signature of Parent(s)/Guardian(s))      Date

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_