



POPE JOHN PAUL II REGIONAL CATHOLIC ELEMENTARY

2875 Manor Road
West Brandywine, Pennsylvania 19320

Phone#610-384-5961
Fax#610-384-5730

www.popejohnpaul2sch.org

Name of Student: _____ Date of Birth: _____ Grade: _____

School: Pope John Paul II Regional Catholic Elementary Fax #: 610-384-5730 Phone #: 610-384-5961

Medication Treatment Plan
To Be Completed by Physician

Diagnosis: _____

Medication, Dosage, Specific Times & Director for Administration:
(Please write each medication, dosage, frequency and time separately) _____

NOTE: Medication must be supplied in the original prescription container. Ask 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, nebulizer 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 Parent(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: _____