LAFAYETTE
PARISH SCHOOL SYSTEM

Health Services
P. O. Drawer 2l58
Lafayette, LA 70502
Phone: 337-521-7281
Fax: 337-521-7285

Physician's Order for Administration of

Solu-Cortef

Parent/Guardian to complete:

Student Name:	DOB:
School:	Grade:

Parent or legal guardian name (print): _____

Parent or legal guardian signature: _____

_____

Licensed Prescriber to complete:

Please provide a student specific description that will permit administration of Solu-cortef.

Relevant Diagnosis: _____

Medication: _____

Strength of medication: _____**Dose** (amount to be given):_____

Frequency: _____**Route:** _____

Time of Dose:

- loss of consciousness
- seizure activity
- obvious broken bone
- fever greater than _____
- other symptoms _____
  - I wish to be notified if the student is brought by ambulance to the hospital _____No ____Yes
  - I wish to be notified if Solu-cortef is administered _____No _____Yes

Prescriber's Name (Printed) _____

Address _____

Phone and fax number _____

_____ _____

Prescriber's Signature **Date**

Any changes in orders for medication require new medication order form. Orders to discontinue must also be written. Orders sent by fax are acceptable.