IDYLLWILD ARTS

Student full name _____

Student date of birth _____

PRESCRIPTION MEDICATION ORDER FORM

Please *do not* send any medication to campus that is written in a foreign language unless it is accompanied by an order that translates the medication into English and has instructions for administration. Idyllwild Arts Health Center is not allowed to administer medications for which we cannot translate the name or instructions.

Medication	Dosage	Frequency	Reason for taking medication:

Allergies:	

Diagnosis:	

Specific directions or information for administration:	
Side effects, contraindications, or possible adverse reactions to be observed:	
Any other medical conditions:	

Practitioner's Name _____

Practitioner's Address _____

Practitioner's Phone Number & Fax Number _____

Signature of Examining Practitioner _____ Date: _____