ST. COLETTA'S OF ILLINOIS
LT. JOSEPH P. KENNEDY SCHOOL

Physician's Orders for Medications at School
2025-2026

Student Name: _____ DOB: _____

PHYSICIAN: Please complete the information and return to the child's parent or to the school directly at:
Fax: 708.429.3467
Email: dangelini@stcil.org

Physician's Printed Name:	Physicians' Office Address/Phone number:
Medication:	Dosage/Frequency of medication:
Time medication is to be administered or under what circumstances:	Diagnosis requiring medication:
Prescription date:	Intended effect of this medication:
Order date:	Must this medication be administered during the school day in order for the child to attend school or to address the student's medication condition? Yes No
Expected side effects (if any):	Time interval for re-evaluation:
Other medication student is receiving:	Any discontinuation of medicine:

Physician's Signature: _____Date: _____