PHYSICIAN’S ORDER FOR PRESCRIBED MEDICATION/OTHER (1)

Child’s Name: ___________________ Date of Birth: _____________
Center: ________________________ Person Administering: ____________________

Name of Medication/Other: ____________________ Diagnosis: _______________________
Date Medication/Other Began: __________ Date Medication/Other Will End: _________________
Dosage: __________________________ Time of Administration: _______________________
Frequency: ________________________ Desired Effects: __________________________
Route of Medication/Other: Oral ______ Inhaled ______ Topical _______ Other ______
Specific Directions or Information for Administration: ________________________________
_____________________________________________________________________________

• Does this disability result in the student’s reduced efficiency in class because of temporary or chronic lack of:
  STRENGTH  ___YES ___NO
  VITALITY ___YES ___NO
  ALERTNESS ___YES ___NO

• With regards to the child’s ability to function in the normal classroom environment what degree would you say the impairment hinders the child’s educational performance?
  NOT AT ALL ___ MILD DEGREE___
  MODERATE DEGREE___ SEVERE DEGREE___

• Is there an accommodation that our center will need to make, in the classroom, for this child?
  ___YES ___NO

If yes, please explain: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Signature of Physician or Dentist ________________ Date ________________

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1304.22 (c)(3)

ENTRY INTO CHILDPLUS
BY: _________________________
DATE: _________________________