

# Physicians Order Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Qualified CSU staff will administer prescription medication if the following conditions are met:

1. This completed form is signed by the prescribing physician and is in the individual's file.
2. The form completely and clearly indicates the consumer's name, medication, and dosages, times, frequency and route of administration.
3. The medicine is received in the original prescription bottle or container with an unaltered pharmacy label attached. Additionally, the label must be current and match the information listed below.
4. All "over-the-counter" medications will be administered to the consumer as prescribed by the physician.
5. All medications will be kept secured in accordance with State regulations and released only to the parent/legal guardian.

Medication	Diagnosis/Purpose	Dosage-Strength/Type	Frequency	Route

\_\_\_\_\_  
Prescribing Physician Signature

\_\_\_\_\_  
Date