

**PHYSICIAN'S ORDER FOR ROUTINE/AS NEEDED MEDICATIONS/PROCEDURES**

Thomas A. Wildey School  
P.O. Box 8 Owensville, Ohio 45160  
Phone: 732-7015 Fax: 732-4950

Completed forms may  
be faxed to:  
513-732-4950

Since medication for the participant listed below cannot be scheduled for other than program hours, it is requested that the medication as listed below be administered by the program nurse or authorized designee in accordance with current state/federal regulations.

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

DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

1. Medication/Procedure (dosage/route/time): \_\_\_\_\_  
Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Discontinue Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Adverse Reactions to be reported: \_\_\_\_\_

2. Medication/Procedure (dosage/route/time): \_\_\_\_\_  
Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Discontinue Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Adverse Reactions to be reported: \_\_\_\_\_

3. Medication/Procedure (dosage/route/time): \_\_\_\_\_  
Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Discontinue Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Adverse Reactions to be reported: \_\_\_\_\_

4. Medication/Procedure (dosage/route/time): \_\_\_\_\_  
Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Discontinue Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Adverse Reactions to be reported: \_\_\_\_\_

5. Medication/Procedure (dosage/route/time): \_\_\_\_\_  
Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Discontinue Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_  
Adverse Reactions to be reported: \_\_\_\_\_

I, the physician, have reviewed and agree upon the above orders.

\_\_\_\_\_  
Date: \_\_\_\_\_ Telephone # \_\_\_\_\_

**Physician's Signature**

I (we) request that the medication as listed above be administered to the above named participant in accordance with the instructions of the physician. I (we) understand that the medication will be given under the supervision of the program nurse. I (we) agree to transport the medication in the original pharmacy labeled container. I (we) agree to notify the program nurse immediately if: (1) we change physicians, (2) the medication or the dosage is changed (changes in the medication regimen require the submission of an updated order form signed by the physician), (3) the administration of the medication is terminated.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date