HEALTH OFFICE
CAMBRIDGE CENTRAL SCHOOL
24 SOUTH PARK STREET
CAMBRIDGE, NEW YORK 12816
518-677-8527 EXT 428

_____ has been under my care for _____
(Name) (Diagnosis)

Please administer:

_____	_____	at _____
Medication	Dose	Time and duration
_____	_____	at _____
Medication	Dose	Time and duration
_____	_____	at _____
Medication	Dose	Time and duration
_____	_____	at _____
Medication	Dose	Time and duration

Additional comments: _____

_____

_____

Physician's Signature: _____

Parent's Signature: _____

Date: _____