REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PHYSICIAN

2017-2018_School Year

Name of student: ____

Name of medication: ____

Dose to be administered: ____

Diagnosis: ____

Time and circumstances of administration: __________________________________

____

Start date: ________________ End date: _________________________________

Name of prescribing Physician: (print)

____

(First) (Last) (MD,DO,DDS,DMD)

Phone number: ____

____

(Physician's Signature) (Date)