REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PHYSICIAN

_____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)