



Physician's Request for Medication Form

The following student is under my care and should receive the medication indicated below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore, must be taken during school hours.

Name of Student: _____

Address: _____

City/State/Zip: _____

Name of Prescribed Medication and Dosage:

Number of Times/Intervals Medication is to be administered: _____

Dates Administration to Begin and End: _____

Adverse or severe reaction that should be reported:

Special Instructions for Administration of Medication:

This medication can be safely administered by non-medical personnel:

Yes

No

(Physician's Name)

(Phone Number)

(Physician's Signature)

(Date)