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: ______________________________

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Number of Times/Intervals Medication is to be Administered: ______________________________

Dates Administration to Begin and End: ______________________________

Adverse or severe reaction that should be reported to physician: ______________________________

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Special Instructions for Administration of Medication: ______________________________

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

☐ Yes ☐ No

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(Physician's Name) (Phone Number)

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(Physician's Signature) (Date)