PHYSICIAN'S REQUEST FORM FOR ADMINISTERING MEDICATION TO STUDENT

Name of Student:_____
Grade: _____ Date: _____

Name of Parent/Guardian:_____
Street Address or PO Box:_____
City:_____ State: _____ Zip Code: _____
Home Telephone:_____ Mobile Telephone:_____
Name of Physician:_____
Address: _____ Phone:_____

I authorize the school personnel to administer medication or procedure as instructed by the physician and agree:

1. To deliver the medication to the school
2. To notify the school if physician is changed.
3. To notify the school if medication, the dosage or procedure is changed or to be eliminated.

Medication and dosage or procedure required:_____
_____
_____

Times required: _____

Possible reactions which should be reported to the physician:_____
_____
_____

Special instructions (storage & sterile requirements):_____
_____
_____

Date medication or procedure no longer needed: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Signature or Parent/Guardian: _____

Date of request: _____

Signature of Principal: _____

Signature(s) of person(s) authorized to administer medication:

_____