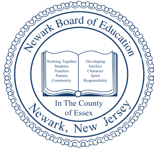

Physician's Request for Medication Administration in School

Student's Name: ____ Birth Date: ________________________

Address: ____ Grade:_______ Home Room:

Parent/Guardian: ____

Physician's Name: ____

Physician's Office Phone #: ____

I request that the following medication be administered by the school nurse, to the above mentioned student.

Diagnosis/Purpose: ____

Name of Medication: ____

Dosage: ____

Time of Circumstance under which medication shall be administered: ______________________________
____

Length of time medication indicated: ____

Possible Side Effects: ____
____
____

Special Instructions: ____
____
____

ADHD medication may be held if student will be attending field trip. Yes______ No_______

Physician's Signature: _____________________________ Date: ______________________________