Physician's Request For Administration of Medication by School Personnel

Date: ______________________________

Name of Pupil:______________________ Date of Birth____________________

Address:____

Condition for which drug is to be given:___________________________________

Medication:____

Dosage, duration , and method of administration (special instructions, possible reactions):____

____

Medication may be administered by a medically trained or untrained designee of the school district

Physician's Name (Please Print)____

Telephone number:____________________ ________________________________

Physician signature