PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student	Date
Teacher	Grade
TO DE COMPLETED DV D	IIVOLOTA NI
TO BE COMPLETED BY P	
Physician's Signature	
Physician's Phone	Physician's Fax
Condition for which medication is p	prescribed
(1) Name of Medication	
Size of tablet (in mg)	or, if liquid (mg/tsp)
	given at school
	at home
	rescribed
(2) Name of Medication	
Size of tablet (in mg)	or, if liquid (mg/tsp)
	given at school
	at home
	prescribed
(3) Name of Medication	
Size of tablet (in mg)	or, if liquid (mg/tsp)
Specific time(s) and doses to be	given at school
	at home
Condition for which modication is n	and a suite and
	prescribed
(4) Name of Medication	
	or, if liquid (mg/tsp)e given at school
specific time(s) and doses to be	
	at home
Length of time	
	NO 16 1 1 1 1
Are there any restrictions? YES	NO If yes, what and how long?
Comments energial instructions and	sible reactions etc.
Comments, special instructions, pos	SIDIC TEACHORS CIC.