

**PHYSICIAN REQUEST FOR  
ADMINISTRATION OF MEDICATION AT SCHOOL**

Student \_\_\_\_\_

Date \_\_\_\_\_

Teacher \_\_\_\_\_

Grade \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

Physician's Name (please print) \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Phone \_\_\_\_\_ Physician's Fax \_\_\_\_\_

Condition for which medication is prescribed \_\_\_\_\_

(1) 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 medication is prescribed \_\_\_\_\_

(2) 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 medication is 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 medication is prescribed \_\_\_\_\_

(4) 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 \_\_\_\_\_

Length of time \_\_\_\_\_

Are there any restrictions? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, what and how long?

Comments, special instructions, possible reactions etc. \_\_\_\_\_

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