



Request for Medication Administration in School

Student's Name: _____

DOB: _____ **Grade:** _____ **Teacher:** _____

Medication: _____

Dose: _____

Route: _____

Time to Administer: _____

Dates to be Administered: _____

Diagnosis: _____

Purpose of Medication: _____

List any possible side effects that might be expected: _____

Signature of Healthcare Provider: _____ **Date:** _____

Print Name: _____ **Phone Number:** _____