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:** ___________________