Physician Statement of Need for Administration of Prescription Medication

(To be completed by physician writing prescription)

Student's Name _____ Birth date _____ Grade _____

Medication to be administered _____

Does this medication have a generic name also? _____

Dosage to be administered _____

Time or interval at which each dosage is to be administered _____

Date to begin administration _____ Date to cease administration _____

Possible adverse reactions _____

List of severe reactions that should be reported to the physician _____

Special instructions for storage of medication _____

Special instructions for administration of medication _____

Physician's name _____

Physician's address _____

Physician's phone number _____

Emergency contact information for physician _____

_____ _____

Physician's Signature Date

Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____Date _____

Work Phone _____Home Phone_____ Cell Phone_____

Please note that all medications must be in its original container.