EASTERN LOCAL SCHOOL DISTRICT HEALTH

PHYSICIAN'S REQUEST for the ADMINISTRATION OF

PRESCRIPTION MEDICATION to a STUDENT

Please fill out the form in its entirety.

Date: _____ Student Name: _____ Grade: ____

Student Address: _____

The above named student is under my care and must take the prescribed medication during school hours.

Name and strength of Medication: _____

Dosage and route of administration: _____

Time or intervals of medication administration: _____

Date administration of medication is to begin: _____

Date administration of medication is to end: _____

Possible reactions to be reported to physician: _____

Special instruction for the administration and/or storage of the medication:

_____

_____

Name of Physician: _____

Physician's Signature: _____

Phone Number where physician can be reached: _____

____ Russellville Elementary ____ Sardinia Elementary ____ Eastern Middle School ____ Eastern High School

Please return this completed form to the student's school building office. Thank you.