

PHYSICIAN'S REQUEST FOR THE  
ADMINISTRATION OF PRESCRIPTION MEDICATION  
BY SCHOOL PERSONNEL

Date: \_\_\_\_\_

\_\_\_\_\_, residing at \_\_\_\_\_

\_\_\_\_\_, a student in the \_\_\_\_\_ school year at

\_\_\_\_\_ School in the Eastern Local School  
District, is under my care and must take medication which has been  
prescribed during the school day.

Name of Medication (as it appears on con-  
tainer in which the drug is stored): \_\_\_\_\_

Dosage and time or intervals: \_\_\_\_\_

Date administration of drug is to begin: \_\_\_\_\_

Date after which the drug should not be  
administered: \_\_\_\_\_

Possible reactions to be reported to  
physician: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Special instruction for the administration  
or storage of the drug: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician