

MEDICATION ADMINISTRATION REQUEST FORM

PRESCRIPTION MEDICATION/PHYSICIAN REQUEST:

Student name: _____ Grade: _____

Diagnosis: _____

Medication: _____ Dosage: _____

Directions for administration (route, time, frequency): _____

Dates of medication administration: _____ to _____

Adverse reactions which should be reported to the physician: _____

Storage requirements: _____

Physician Signature: _____ Date: _____

Physician name(printed): _____ Phone: _____

OVER-THE-COUNTER MEDICATION/PARENT REQUEST:

Student name: _____ Grade: _____

Medication: _____ Dosage: _____

Directions for administration (route, time, frequency): _____

Reason for medication usage: _____

Dates of medication administration: _____ to _____

Parent signature: _____ Date: _____

Any changes in the above request requires a new form to be filled out and returned to the health room.

The above medication ...

_____ was given as requested and documented on the medication sheet.

_____ was not needed during the above dated administration period.

Signature: _____ Title: _____ Date: _____