



## Request for Administration of Medication

This form is for “long term” or emergency administration of medication, e.g. epilepsy, anaphylaxis, etc.

### A. To Be Completed By Parent or Guardian

Student Name		DOB YYYYMMDD	
Parent / Guardian		Relationship	
Work Phone:	Home Phone	Cell Phone	
Work Phone:	Home Phone	Cell Phone	
Physician Name:		Phone	

### B. To Be Completed By Prescribing Physician

Condition(s) which make medication necessary:


	Name of Medication	Dosage	Directions For Use / Storage Instructions
1.			
2.			
3.			
4.			
5.			

**Additional Comments (possible reactions, consequences of missing medication, etc.)**


Physician's Signature	Date
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