Physician Statement of Need for Prescription Medication

(To be completed by Physician. One form per medication.)

Student's Name_____ Birthdate_____

Address_____ Phone_____

Grade_____ Parent's/Guardian's Name_____

Reason for medication	
Medication to be administered (trade & generic names)	
Dosage to be administered	
Dosage time or interval	
Common adverse reactions	
Reactions that necessitate calling 911	
Special instructions for storage and/or administration of medication	
Date to begin medication	
Date to cease medication	

Physician's Name (Please Print)_____ Phone_____

Address_____

Physician's Signature_____ Date_____