Authorized Medication Administration Request

Student Information

Student Name:

Date of Birth:

Grade/Teacher:

Medication Information

Medication Name:

Dosage:

Time to be administered:

Route (oral, topical, etc.):

Reason for Medication:

Parent/Guardian Authorization

Parent/Guardian Name:

Phone Number:

Signature:

Date:

Physician Authorization

Physician Name:

Phone Number:

Signature:

Date:

Submit Request