Main Street School
Health Office
40 Main Street
Exeter, NH 03833
(603) 775-8948

PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION

Student's Name: _____

Diagnosis: _____

Medication Name: _____

Dosage: _____ Route: _____

Frequency/Time Schedule: _____

Possible adverse reactions/side effects:

_____

_____

Other medications the student is taking: _____

_____

Any other information you feel the school nurse needs to care for the student?

_____

Thank you for your information.

Physician's signature: _____

Date: _____