ROCORI AREA SCHOOLS
ISD #750
Physician's Request for Prescription Medication Administration

Student's Name: ______________________________ Birth Date: __________________

Grade: ____________________________ School Year: __________________________

School: ____

Medication Information
(To be completed by Physician)

Medication: ____

Route of Administration: ____

Dosage of Medication: ____

Frequency or Time Schedule: ____

Adverse Reactions or Side Effects: ____

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Diagnosis: ____

____

Specific information you feel would be beneficial to the school: _______________

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_________________________________ _________________________________
Physician Signature Date

_________________________________ _________________________________
Clinic Telephone Number

Parent/Guardian Consent
(To be completed by Parent/Guardian)

I understand I must provide this medication in the original, properly labeled bottle. I release school district #750 and school personnel from any liability in relation to the administration of this medication at school.

_________________________________ _________________________________
Parent/Guardian Signature Date