Eleanor Kolitz
HEBREW LANGUAGE ACADEMY
אלינור קוליץ האקדמיה לשפה העברית

Medication Administration Request
(Complete separate form for each medication)

School Name:____

Student:_________________________________ DOB:_____________ Age:_________

Grade: __________ Teacher/Classroom: _______________________________________

To be completed by physician or authorized prescriber

Name of Medication: ____

Reason medication being administered: ____

Form of medication/treatment:

☐Tablet/capsule ☐Liquid ☐Inhaler ☐Nebulizer ☐Other_______________

Instructions (Dose and Schedule to be given at school): _______________________________

____

Restrictions and/or important side effects: ☐None anticipated ☐ Yes. Please describe:

Any other concerns/information: ____

____

Physician signature:____

Physician printed name and phone number_______________________________________

To be completed by parent/guardian

I give permission for my child ___________________________________, to receive the above medication at school, according to school policy. I also give permission for an authorized employee of the school to contact the above named physician for any questions or concerns regarding this medication.

Date __________ Signature ____________________________ Relationship ___________

08/01/2013