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 _____