



Physician Statement of Need

Student's Name _____ Birthdate _____

Student's Address _____

School _____ Grade _____

Medication to be administered _____

Reason for medication _____

Does this medication have a generic name also? _____

Dosage to be administered _____

Time or interval at which each dosage is to be administered _____

Date to begin administration _____

Date to cease administration _____

Possible adverse reactions _____

List of severe reactions that should be reported to the physician _____

Special instructions for storage of medication _____

Special instructions for administration of medication _____

Physician's name _____

Physician's address _____

Physician's phone number _____

Emergency contact information for physician _____

Physician's Signature

Date