# Physician Statement of Need

Student's Name ______________________ Birthdate ______________

Student's Address ________________________________________

School ___________________________ Grade ________________

Medication to be administered ______________________________

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