Fax: 435-797-3668

Prescribing Practitioner's Request for Medication Administration in School

(To be completed by the prescribing practitioner and returned to school to become a part of the cumulative health record)

Name of Student_____ Birth Date_____

Name of School: Edith Bowen Laboratory School School Year_____

The following medication(s) has/have been prescribed for the treatment of the following condition(s):

Name of Medication	Dosage	Time	How

Comments:_____

The above-named student is in need of the above named medication/drug during regular school hours to maintain his/her physical health. I advise and request that non-medical school personnel be allowed to administer this medication/drug in accordance with the following instructions:

Instructions:_____

Prescribing Practitioner:_____

Signature:_____ Date:_____

Address:_____

Telephone Number:_____