



## PHYSICIANS STATEMENT OF NEED

Please Print

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Medication to be administered: \_\_\_\_\_

Trade Name/Generic Name: \_\_\_\_\_

Dosage to be administered: \_\_\_\_\_

Time interval in which each dose is to be administered: \_\_\_\_\_

Date to begin administration: \_\_\_\_\_ Date to cease: \_\_\_\_\_

Possible adverse reactions: \_\_\_\_\_

Reactions that should be reported immediately to Physician: \_\_\_\_\_

\_\_\_\_\_

Special instructions for storage: \_\_\_\_\_

Special instructions for administration of medication: \_\_\_\_\_

\_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physicians Address: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Emergency contact information for physician: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form must be filled out prior to the administration of any medication.