Birchwood School of Hawken

REQUEST FOR THE ADMINISTRATION OF MEDICATION BY BIRCHWOOD PERSONNEL

PHYSICIAN'S REQUEST:

Name of student _____ grade _____

residing at (student address) _____

is under my care and should receive _____,

dosage _____, at the following times _____.

Special instructions for administration are: _____

Possible side effects to watch for are: _____

Start date _____ Expiration date _____

Physician's signature _____ Date _____

Physician's phone number _____

PARENT'S REQUEST:

I hereby request and give my permission to Birchwood School of Hawken's designee to administer the following medication to my child.

Name of child _____ Grade _____

Address _____

Name of medication _____ Dosage_____

At the following times _____ Start date_____ Exp. _____

Parent Signature _____ Date _____