

## Physician Consent for Medication Administration

Date: \_\_\_\_\_ Name of Student: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Time Interval: \_\_\_\_\_

Diagnosis or reason for treatment: \_\_\_\_\_

Side effects to look for: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Signature: \_\_\_\_\_