

**HURST-EULESS-BEDFORD I.S.D.**  
**PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICINE**  
**SECONDARY SCHOOLS**

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

School: \_\_\_\_\_ School's Phone: \_\_\_\_\_ School's Fax # \_\_\_\_\_

1. Condition for which prescribed treatment is required:

2. Precautions, unfavorable reactions, limitations after administration of medicine or procedure:

**3.\*Student may carry inhaler or epinephrine**

