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 epinepa*_ _