Physician Request for Administration of Medication
Tipp Monroe Community Services / Camp Kern

PHYSICAN MUST COMPLETE THIS SIDE OF THE FORM

Patient Information:

Name: _____

Address: _____

ALLERGIES: ☐ **YES** ☐ **NO**

PLEASE LIST ALL ALLERGIES: _____

It is requested that the medications listed below be administered by the Tipp Monroe Community Services volunteer nurse.

Name of Drug	Dosage	Time	Route/Method	Begin Date	End Date	Possible Reactions/Special Instructions

If medication is an ASTHMA INHALER, please complete the following:

- Must the child carry and self-administer the asthma inhaler: YES NO
- Procedure to follow in the event that the medication does not produce the expected relief from the child's asthma attack:
- Adverse reactions for unauthorized user of asthma inhaler.

Physician's Signature: _____

Physician's Address: _____

Physician's Phone: _____ Date of this request: _____