Physician Request for Self-Administration of Medication

Name of Student_____ DOB_____

School_____

The above named student has a diagnosis of _____.

I am requesting that the above named student take the following medication during school hours.

_____

Name of Medication Type of Medication (tablet, liquid, capsule)

_____

Dosage Time(s) to be given

_____

Possible side affects

I certify that _____(name of student) has been instructed in the use and

self-administration of _____(name of medication.)

S/he understands the need for the medication and the necessity to report to school personnel any unusual side effects. S/he is capable of using this medication independently and understands the result in giving, sharing or selling this medication to another person.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____

Phone number of Physician Signature of Physician Date

_____

Address of Physician Print name of Physician