PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

_____ _____

Name of Student *Birthdate*

_____ _____

Address *Phone Number*

_____ _____

City *Zip*

TO:
Principal Judy Pappas **School** St. James
School Nurses Julie Baker & Diane Westerkamp

The above named student has_____
Name of Disease or Syndrome

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

_____

Name of Medication *(inhaler, capsule, injectable, liquid)*

_____

Dosage *Time(s) to be given*

_____

Possible Side Effects

I certify that_____has been instructed in the use and
Name of Student

self-administration of_____.
Name of Medication

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

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

Physician Name_____Phone_____

Physician Signature_____Date_____