

PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student

Birthdate

Address

City

Zip

Telephone Number

TO:

Principal _____

School _____

The above named pupil has _____

(Name of Disease or Syndrome)

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

Name of Medication

Type of Medication (Tablet, Liquid, Capsule, Inhaler)

Dosage

Time(s) to be given

Possible Side Effects

I certify that _____ has been instructed in the use
(Student)

and 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 # 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

Date

*Refer to: Illinois Department of Human Services and Illinois State Board of Education
"Recommended Guidelines for Medication Administration in Schools"*