PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Dear Doctor:

The parent/guardian of _____ has requested that we administer medication(s), namely _____ to the student during the school day for _____.
(diagnosis)

It is our procedure to request the medication be given before or after school hours whenever possible.

If it is essential that the student receive the medication(s) during school hours, please complete the following information.

NAME OF MEDICATION(S) _____

DOSAGE _____

HOW TO BE ADMINISTERED (ORAL OR INJECTION) _____

TIME SCHEDULE FOR ADMINISTRATION _____

DURATION OF MEDICATION ADMINISTRATION _____

POSSIBLE SIDE EFFECTS OR CONTRAINDICATIONS _____

CURTAILMENT OF SPECIFIC SCHOOL ACTIVITY (SPORTS, SHOP, LAB, DRIVERS TRAINING, ETC. _____

OTHER MEDICATIONS PRESCRIBED BY PHYSICIAN THAT STUDENT IS TAKING OUTSIDE OF SCHOOL HOURS _____

_____ _____
Date Physician Signature

_____
Physician Telephone Number

_____
Parent/Guardian Signature