

Physician Request for Self Administration of Medication

Name of Student: _____ Birthdate: _____

Address: _____ Phone: _____

School: _____

The above named student 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: _____

Dosage: _____ Time to be given: _____

Possible side effects: _____

I certify that _____ has been instructed in the use and self-
(Name of student)
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.

Doctor's Name: _____ Phone Number: _____

Doctor's Signature: _____ Date: _____

Doctor's Address: _____

Parent's Signature: _____ Date: _____

Parent's phone number: _____