

Sample Physician Request For Self-Administration of Medication

Name of Student Birthdate

Address City St 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 or Capsule)

Dosage Time(s) to be given

Possible Side Affects

I certify that _____ has been instructed in the use 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 Physician

Signature of Physician

Date

Address of Physician

Print Name of Physician