Administration of Medication During School Hours: Physician's Statement

Student: ______________________________ Date of Birth: ______________________________

School: ______________________________

To be completed by Physician:

In order to accommodate the student named above, the following information is required:

i) Reason for Medication: ______________________________

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ii) Name of Drug: ______________________________

iii) Dosage/ Frequency of Administration/ Anticipated duration of medication program: ______________________________

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iv) Possible Side Effects/ Action Necessary: ______________________________

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The medical procedures prescribed herein for ______________________, will be necessary for the following duration:
Name

Commencing on ______________________ concluding on ______________________.
Date Date

*This information may remain on file if there are no changes to this student's medical condition.

To be completed by Physician:

v) Other (e.g. Storage and Disposal Requirements):

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Telephone

______________________________ ______________________________
Physician's Signature Date