PHYSICIAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

______________________________ ______________________________
Name of Student Address

______________________________ ______________________________
SchoolClass/Grade

I have prescribed the following medication ______________________________
____
____

Beginning Date ____________________ Ending Date ____________________

Dosage, instructions, or precautions: ____________________
____
____
____

Report the following side effects to my office immediately ____________________
____
____
____
____
____

Physician's Signature ______________________________ Telephone ____________

Printed/Typed Name ______________________________ Date ____________________

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

____
____

____
Principal

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