

**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. It is our procedure to request that 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:

DIAGNOSIS _____

NAME OF MEDICATION(S) _____

DOSAGE _____

HOW TO BE ADMINISTERED (ORAL) _____

TIME SCHEDULE FOR ADMINISTRATION _____

POSSIBLE SIDE EFFECTS OR CONTRAINDICATIONS _____

CURTAILMENT OF SPECIFIC SCHOOL ACTIVITY (SPORTS, SHOP, LAB, DRIVER'S TRAINING, ETC.) _____

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

IS STUDENT CAPABLE OF SELF-ADMINISTRATION: _____

THE STUDENT HAS BEEN TRAINED IN PROPER SELF-ADMINISTRATION OF ASTHMA INHALER
YES _____ NO _____ N/A _____

STUDENT MAY CARRY ASTHMA INHALER IN SCHOOL YES _____ NO _____

Date

Physician's Signature

Physician's Telephone Number

School Nurse

Thank you for your cooperation