SEYMOUR COMMUNITY SCHOOLS
HEALTH SERVICES

Physician Request For Self-Administration of Medication

Name of Student _____ Birthdate _____

City _____ 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
(Name of Student)

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 of Physician _____ Signature of Physician _____ Date _____

Address of Physician _____ Print Name of Physician _____ Date _____

Parent Signature _____ Date _____