SEYMOUR COMMUNITY SCHOOLS HEALTH SERVICES

Physician Request For Self-Administration of Medication

Name of Student		Birthdate		
City	Zip	Telephone Number		
TO:				
Principal:	and the second seco	Mole will achieve		
School:	nyayiya inti ay kanaasi iyo iyo oo o			
The above named pupil ha	1\$ <u>-</u>	(Name of Disease or Syndrome)	The state of the s	
		(Name of Disease or Syndrome)		
I am requesting that the ab	oove named student ta	ke the following medication during school	hours.	
Name of Medication	and an arthur de l'air facturi de l'archivit de l'archivi	Type of Medication (Tablet, Liquid or Capsule)		
Dosage		Time(s) to be given	Time(s) to be given	
Possible Side Affects		÷ manggunanggananigi ng ng gangang na 		
I certify that(Name of		has been instructed in the use and self-	administration	
(Name of	Student)			
of	a period the company of the engine first t			
	(Name of Medi	cation)		
He/she understands the necunity unusual side effects. He/sl	ed for the medication, he is capable of using	and the necessity to report to school persorthis medication independently.	nnel any	
may be reached at the fol	lowing phone # in the	event of a reaction to the medication or an	omergency:	
hone Number of Physicia	20:	Signature of Physician	Date	
Address of Physician		Print Name of Physician	Date	
Parent Signature	Date			