Administration of Medication During School Hours: Physician's Statement

Insert Chart (personal data)

Pupil:_____ D.O.B.:_____

School:_____ Placement:_____

Note: This form is completed in respect of the in-school administration of medication.

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.

****

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

i) Reason for Medication: _____

_____

_____

ii) Name of Drug: _____

iii) Dosage / Frequency of Administration / Anticipated Duration of Medication Program:

_____

_____

_____

iv) Possible Side Effects / Action Necessary:

_____

_____

_____

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

_____

_____

_____

_____
Telephone

_____ _____
Date **Physician's Signature**