

Administration of Medication During School Hours: Physician's Statement

Student: _____	Date of Birth: _____
School: _____	Placement: _____

To be completed by Physician:

In order to accommodate the student 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: _____

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.

To be completed by Physician:

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

Telephone

Physician's Signature

Date