

Administration of Medication During School Hours: Physician's Statement

Pupil: \_\_\_\_\_

D.O.B. \_\_\_\_\_

School: \_\_\_\_\_

Placement: \_\_\_\_\_

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

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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):

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Telephone

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Date

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Physician's Signature