

PHYSICIAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

Name of Student _____ Address _____

School _____ Class/Grade _____

I have prescribed the following medication _____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions: _____

Report the following side effects to my office immediately _____

Physician's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

Principal