School Health Services

St. Augustine School
2017-2018 School Year

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____, _____ who resides at _____
Name of Student | Date of Birth | Address

_____, is under my care and should receive the following

medication indicated below:

_____ _____ _____
Name of prescribed drug | Dosage | Number of time/intervals for administration

Special instructions for administration: _____

_____

Reaction(s) and/or possible side effects to be reported to physician: _____

_____

Beginning and expiration date of this request: _____

It is not possible for the above specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that the specified medication be administered during school hours. The medication provided shall be in the original container obtained by the parent/guardian from the pharmacist. The medication can be safely administered by non-medical personnel.

_____
Physician's Name | Physician's Signature | Date | Telephone

NOTE: This form should be updated no less than once each school year.