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):

_____

_____

_____

_____
Telephone

_____ _____
Date Physician=s Signature