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

DATE: ____________________ SCHOOL YEAR: ______________

______________________, residing at ______________________, and a
(Name of Student) (Address)
student in the __________ grade at the ____________________ school in the Georgetown Exempted Village School District, is under my care and must take medication which I have prescribed during the school day:

1. Name of Medication: (as it appears on container in which the drug is stored): ______________
2. Dosage and time or intervals: ______________
3. Date administration of drug is to begin: ______________
4. Date after which the drug should not be administered: ______________
5. Possible adverse reactions to be reported to physician: ______________
6. Special instructions for the administration or storage of the drug: ______________
7. Student has permission to carry asthma inhaler at school: **Yes** _____ **No** _____

Name of Physician: ____________________

Primary Telephone Number: ____________________

Secondary Telephone Number: ____________________

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Signature of Physician

9/21/11
1/13