

Physician Request for Self-Administration of Medication

Name of Student

Date of Birth

To: Principal, Notre Dame Parish School, Clarendon Hills, Illinois:

The above named child has _____

I am requesting that the above-named student be allowed to take the following medication during school hours or during school-related activities:

Name of Medication Type of Medication(tablet, liquid, capsule, inhaler, injectable)

Dosage Time(s) to be taken or administered

Possible Side effects

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision (Circle one): Yes No

Physician's Signature

Date signed

Physician's Name

Emergency telephone number

Address: _____