

## 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: \_\_\_\_\_