SEYMOUR COMMUNITY SCHOOLS
HEALTH SERVICES

Physician Request For Self-Administration of Medication

__________________________________ ______________________________
Name of Student Birthday

__________________________________ ______________________________
City Telephone Number

TO:

Principal: ___________________________

School: ____________________________

The above named pupil has ____
(Name of Disease or syndrome)
I am requesting that the above named student take the following medication during school hours.

____
Name of Medication Type of Medication (Tablet, Liquid or Capsule)

____
Dosage Time(s) to be give

____
Possible Side Effects

I certify that ___________________________ has been instructed in the use and self-administration
(Name of Student)
of ____
(Name of Medication)

He/ She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He /She is capable of using this medication independently/

I may be reached at the following phone # in the event of a reaction to the medication of an emergency:

_________________________________ ______________________________________
Phone Number of Physician Signature of Physician Date

_________________________________ ______________________________________
Address of Physician Print Name of Physician Date

____
Parent Signature Date