ALIQUIPPA SCHOOL DISTRICT

JR/SR High SCHOOL

PHYSICIANS'S REQUEST FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL HOURS

Date: _____

Dear Doctor:
The parent/guardian of _____
has requested that school personnel administer medication (s), to the student during the school day.

It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication (s) during school hours please complete the following.

Name of medication: _____

Dosage: _____ How to administer: _____

Time schedule for administering: _____

Possible side effects or contraindications: _____

_____

Curtailment of any school activity
(sports, lab, shop, gym, etc.) _____

Other medication (s) prescribed that student is taking outside school hours?

_____

Is student capable of self administration?

_____

Physician's Signature: _____

Physician's Telephone: _____

Parent/guardian Signature: _____

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