Resurrection
COLLEGE PREP HIGH SCHOOL
Caritate et Veritate

Physician Request for Self-Administration of Medication

_____ _____
Name of Student Birthdate

_____
Address

_____ _____ (_____) _____
City Zip Code Home Telephone Number

TO: Principal, Resurrection College Prep High School

The above named pupil has _____.
(Name of disease, syndrome or medical condition)

I am requesting that the above named student take the following medication during school hours.

_____
Name of Medication Form of medication's administration (ie: tablet, inhaler, liquid, pump)

_____
Dosage Time (s) to be given

_____
Possible side effects

I certify that _____ has been instructed in the use and
(Name of Student)

self-administration of _____.
(Name of Medicine)

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

I may be reached at the following phone number in the event of a reaction to the mediation or an emergency:

_____ _____
Phone Number of Physician Physician's Signature (Date)

_____ _____
Address of Physician Print Name of Physician (Date)