

Silsbee Independent School District
Health Services

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION
BY SCHOOL PERSONNEL

Name of Student: _____

Date of Birth: _____

School: Silsbee High School _____ Grade: _____

Condition for which drug is prescribed: _____

Medication:

Name: _____

Dosage: _____

Method of administration: _____

Side effects: _____

Special instructions: _____

* The above medication may not be scheduled for other than school hours. It may be administered by a medically untrained designate of the school nurse.

Physician's Name (please print): _____

Office telephone number: _____

Physician's Signature

Date

Parent or Guardian Signature

Date