Woodstock Community Unit School District 200
Physician Request For Self-Administration of Medication

_____ _____
Name of Student Birthdate

_____
Address

_____ _____
City Zip 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

_____
Dosage Time(s) to be given

_____
Possible Side Effects

I certify that _____has been instructed in the use and self-administration 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 or an emergency:

_____ _____
Phone Number of Physician Signature of Physician Date

_____ _____
Address of Physician Print Name of Physician Date