

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