



**BIG SPRING SCHOOL DISTRICT  
PRIVATE PHYSICIAN'S REQUEST  
FOR SUPERVISION OF THE ADMINISTRATION  
OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS  
DURING SCHOOL HOURS**

Student's name: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher's name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Grade: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time(s) of administration/special directions: \_\_\_\_\_

Duration of medication administration: \_\_\_\_\_

Curtailment/restriction/limitation of normal school activities (e.g. sports, shop, driver's education, labs, etc.): \_\_\_\_\_

Can a dose be skipped for a field trip or out of school activity? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is student capable of self-administration? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the medicine need to be refrigerated? \_\_\_\_\_ Yes \_\_\_\_\_ No

May student carry an inhaler/Epi-Pen? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Phone Number

**PLEASE NOTE: This request for administration of medication will be honored for one school year. It is preferred that all medicines be given at home. Medication to be given three times a day should be given before school, immediately after school, and at bedtime unless otherwise specified by the physician.**

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I hereby request that Big Spring School District personnel supervise the administration of the above-mentioned prescription or non-prescription medication, as described, to my child during school hours.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

Home phone (Father) \_\_\_\_\_ Work (Father) \_\_\_\_\_ Cell (Father) \_\_\_\_\_

Home phone (Mother) \_\_\_\_\_ Work (Mother) \_\_\_\_\_ Cell (Mother) \_\_\_\_\_

Oak Flat – 776-2445  
Fax – 776-6005

High School – 776-2450  
Fax- 776-2433

Newville – 776-2435  
Fax – 776-2038

Middle School – 776-2471  
Fax – 776-2468

Mt. Rock – 776-2425  
(Fax - 776- 2026)

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