Trinity Lutheran School- Physician Request for Self- Administration of Medication

10247 S Prairie Rd. Red Bud, IL 62278 (618) 282-2881 FAX: (618) 282-4045

______________________________ ____________________

Name of Student Birthdate

______________________________ ____________________

City Zip Telephone #

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 (Tablet, Liquid or Capsule)

____

Dosage Time(s) to be given

____

Possible Side Effects

I certify that____________________________ has been instructed in the use and self-

(Name of Student)

Adminstration of____

(Name of Medication)

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency

______________________________ ______________________________

Phone # of Physician Signature of Physician Date

______________________________ ______________________________

Address of Physician Print Name of Physician Date