

(school letterhead)

**PRIVATE PHYSICIAN REQUEST FOR
ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

Dear Doctor:

The parent/guardian of _____ has requested that we administer medication(s), namely _____ to the student during the school day for (diagnosis):

It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication(s) during school hours, please complete the following information and return this form to us. Thank you for your cooperation.

School Nurse

Name of medication(s): _____

Dosage: _____

How to be administered (orally or injected): _____

Time schedule for administration: _____

Duration of medication administration: _____

Possible side effects or contraindications: _____

Curtailement of specific school activity (e.g., gym class, etc.) _____

Other medications prescribed by physician that student is taking outside of school hours: _____

Is student capable of self-administration? _____

(date)

(physician signature)

(physician telephone number)