St. Luke Lutheran School, Cabot

PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Dear Doctor:
In general medication will not be given during the school day. If, however, it is absolutely necessary, the form below must be completed.

INSTRUCTIONS: To school personnel for the dispensing of medication required during the school day. (Please type or print.)

_____ _____ _____
(Name of child) (Grade) (Name of Medication)

_____ _____
(Print: Doctor prescribing medicine) (Doctor's telephone number)

Diagnosis:_____

Purpose of medication:_____

_____ _____
(Date Prescription Begins) (Date Prescription Ends)

_____ _____
(Dosage) (Time Dosage is to be Taken)

Special instructions, if any:_____
(Pills crushed, with water, etc.)

Self-administration? _____Yes _____No

Does the medication require refrigeration? _____Yes _____No

Possible Reaction:_____

Procedure to be followed if reaction should occur:_____

_____

Person to contact:_____ Phone Number:_____

Please return this form with the medication.

I hereby authorize the medication listed above to be administered to:

_____
(Name of Child)

_____ _____
(Date) (Signature of Physician)

I hereby authorize the medication listed above to be administered by the proper school personnel to my child:

_____ _____
(Parental Signature) (Date)