

Parent (Family) Last Name _____

Diocese of Las Vegas
Saint Anne Catholic School
2009-2010

**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION
OF MEDICATION BY SCHOOL PERSONNEL**

_____, _____, who resides at
Name of Student Date of Birth

Street City

State Zip Code Phone Number

is under my care and should receive the following medication indicated below:

Name of prescribed drug Dosage # of times/intervals for administration

Specific instructions for administration

Reaction(s) and/or possible side effects to be reported to physician

Beginning date of this request Expiration date of this request

It is not possible for the above specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that that specified medication be administered during school hours. The medication provided shall be in the original container obtained by the parent/guardian from the pharmacist. This medication can be safely administered by non-medical personnel.

Physician's Name (Please print)

Physician's Address Phone Number

Physician's Signature Date