

PHYSICAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student name on the reverse side.

I have prescribed the following medication _____

Beginning Date _____ Ending Date _____

Dosage, instructions, or precautions (including possible side effects): _____

I have prescribed the following treatment _____

Beginning Date _____ Ending Date _____

Physician's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

Principal