Physician Request for Self-Administration of Medication

Name of Student:

Illness/Medical Condition:

Date of Birth: Grade:

To: Principal, Dr. Emily Hanlon, St. Benedict School, Blue Island, IL

I am requesting the above-named student be allowed to take the following medication during school hours or during school related activities.

Name of Medication:

Type of Medication:

Tablet Liquid Capsule Inhaler Injectable

Dosage:

Possible side effects:

I certify that this student has been instructed in the use and self-administration of this medication and is capable of

self-administering the medication independently and without supervision.

Yes No

For **ASTHMA AND ALLERGY CONDITIONS ONLY**. I also request that this student be allowed to carry the above-described medication on their person during school hours and during school related activities in order to facilitate the self-administration of the medication as needed.

Yes No

Signature of Physician:

Name of Physician:

Address, City, State, Zip Code:

Emergency Telephone Number: