SAINT RITA OF CASCIA HIGH SCHOOL

AN AUGUSTINIAN COLLEGE PREP SCHOOL

Veritas † Unitas † Caritas

Physician's Request for Administration of Medication

Name of Student _____ Date of Birth _____

Address _____ City/State/Zip _____ Parent Phone Number _____

The above named student has _____

(Name of disease, condition or syndrome)

I am requesting that the above named student be administered the following medication during school hours:

_____

(Medication name and type, i.e tablet, liquid, inhaler, injection; emergency or routine)

_____

(Dosage, route, time to be taken, i.e. scheduled time or PRN)

Possible side effects: _____

Physician's Name _____ Signature _____ Date _____

Address _____ Phone Number _____ Fax Number _____

**This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.*

**Medical conditions qualifying for self-carry and self-administration include but may not be limited to asthma, certain allergies, epilepsy, and diabetes. Please complete a separate form for each medication.*