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PRINCE OF PEACE
CATHOLIC SCHOOL

Physician Request for Self-Administration of Medication

_____ _____
Name of Student Date of Birth

To:

Principal, _____, School, _____, Illinois:

The above named child has _____
Name of Illness or Medical Condition

I am requesting that 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 Time(s) to be taken or administered

_____
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. (Circle One):

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 facilitate the self-administration of the medication as needed. (Circle One):

Yes No

_____ _____
Signature of Physician Date

_____
Name of Physician

_____ _____
Address Emergency telephone number

_____
City, State