Physician Request for Self-Administration of Medication

Name of Student:_____

Illness/Medical Condition:_____

Date of Birth:_____ Grade:_____

To: Principal, Dr. Emily Hanlon, St. Walter-St. Benedict School, Chicago and Blue Island Campuses

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:_____