St. Thomas the Apostle Catholic School
265 King St. Crystal Lake, IL 60014
Phone- 815.459.0496 Fax- 815.459.0591
www.stthomascl.org

Physician Request for Self-Administration of Medication

____
Date

__________________________ ________________ __________________________
Student Last Name, First Name Student DOB Student Grade/Homeroom

____
Student Diagnosis

I am requesting that the above named student take the following medication during school hours.

_______________________________ _______________________________
Name of Medication Route

_______________________________ _______________________________
Dose Frequency/Time(s) to be administered

_________/_________/__________ to _________/_________/__________
Period of time medication is to be available for administration during school hours

____
Anticipated results/Possible adverse effects that school staff should be aware of

____
Other medications student is receiving

I certify that __________________________ has been instructed in the use and self-administration of
(Student Name)
___________________. He/She understands the need for the medication, and the necessity to report
(Name of Medication)
to school personnel any unusual side effects. He/She is capable of using this medication independently.

I recommend re-evaluating the need for this medication on___________________________________.
(Date)

I may be reached at the following in the event of a reaction to the medication or an emergency.

____

_______________________________ ______________________________________
Signature of Physician/Prescriber Date

_______________________________ ______________________________________
Name of Practice, Address and Phone Number of Physician/Prescriber
Print Name of Physician/Prescriber Date