Anna-Jonesboro Community High School District 81

2020/2021

Physician Request/Approval for Self-Administration of Medication

______________________________ _____________________

Student's name **Birthdate**

To:
Principal: ___________________________

School: _____________________________

The above named pupil has ____.
(Name of Condition)

I am requesting that the above named student self-carry and self-administer the following medication during school hours:

_________________________________ ____________________________________

(Name of Medication) **(Type of Medication - tablet, liquid, capsule)**

_____________________ _______________ _______________________________

(Dosage) **(Time(s) to be taken)** **(Possible Side Effects)**

I certify that ___________________________________ has been instructed in the use and self-administration of the above stated medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I may be reached at the following phone # in the event of a reaction or emergency:

____________________ ______________________________ ________________

Physician Phone # **Physician Signature** **Date signed**