ALL SOULS CATHOLIC SCHOOL

A CATHOLIC EDUCATION

479 Miller Avenue - South San Francisco, California 94080 - (650) 583-3562

PHYSICIAN'S STATEMENT REGARDING ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

PLEASE SCHEDULE MEDICATION OUTSIDE OF THE SCHOOL HOURS WHENEVER POSSIBLE

1. Name of pupil _____ Date of Birth ___/___/___
2. Address _____ Telephone _____
3. Condition for which medication is to be given _____
4. Name of medication _____
5. Method of administration: Oral _____ Inhalator _____ Injection _____ Other _____
6. Dose _____ Schedule of doses _____
7. The medication is to be continued as above until _____
8. Precautions advised _____

   Possible reactions to medication _____

   Actions to be taken in case of reaction to medication _____

   _____
9. Check one below:

   _____ I give this pupil permission to **self administer** the above medication.

   _____ I authorize designated school personnel to administer the above medication.
10. Print name and address of physician Date _____

    _____ Phone _____

    _____

    _____

    _____
    Signature of Physician

PARENT'S OR GUARDIAN'S REQUEST FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL AND WAIVER AND RELEASE FROM LIABILITY

The undersigned hereby requests _____ School to assist

_____ in the matters set forth in the above Physicians statement.