# PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL BUILDING DURING SCHOOL HOURS

To The Principal of North Shore Middle School, Date_____

Name of Child_____ DOB _____

Diagnosis_____

In order to keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.

Name of medication:_____

Dosage: _____

Frequency: _____

Common side effects:_____

_____

Remarks: _____

_____

_____
Physicians Signature

_____
Physician's Name (Print or type)

_____
Telephone Number