GALENA PARK I.S.D.

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

Date: _____

Student's Name: _____ 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: _____

_____

Comment: _____

_____
Physician's Name (please print)

_____
Physician's Signature

_____
Physician's Telephone Number