

BARBERS HILL INDEPENDENT SCHOOL DISTRICT
Primary Campus
School Health Service

Physician's Request for Administration of Medication by School Personnel

Student's Name: _____ Date of Birth: _____

Address: _____

Condition for which drug is to be given: _____

Medication: _____

Dosage and method of administration (*special instructions, possible reactions if any, etc.*):

The above medication may not be scheduled for other than school hours. It may be administered by medically untrained faculty or staff member designated by the principal.

Physician's Name (*please print*): _____

Telephone Number: _____

Parent's Signature

Physician's Signature

Home Telephone: _____

Date: _____

Business Telephone: _____

Alternate Physician: _____

Telephone Number: _____

Filled in nurse's office: _____

By: _____

