

*Diocese of Las Vegas*

SCHOOL HEALTH SERVICES

ST. VIATOR PARISH SCHOOL

2021-2022 SCHOOL YEAR

**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION  
OF MEDICATION BY SCHOOL PERSONNEL**

\_\_\_\_\_, \_\_\_\_\_, who resides at  
Name of Student (DOB)  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Street City State Zip Code

is under my care and should receive the following medication indicated below:

_____ Name of prescribed drug	_____ Dosage	_____ Number of times/intervals for administration
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\_\_\_\_\_  
Specific instructions for administration

\_\_\_\_\_  
Reaction(s) and/or possible side effects to be reported to physician

\_\_\_\_\_  
Beginning and expiration date of this request

It is not possible for the above specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that that specified medication be administered during school hours. The medication provided shall be in the original container obtained by the parent/guardian from the pharmacist. This medication can be safely administered by non-medical personnel.

\_\_\_\_\_  
Physician's Name Physician's Signature Date Phone Number