

Diocese of Las Vegas

SCHOOL HEALTH SERVICES

ST. VIATOR PARISH SCHOOL

2023-2024 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
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