Diocese of Las Vegas

SCHOOL HEALTH SERVICES

ST. VIATOR PARISH SCHOOL

2024-2025 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

_____
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