Physician Request for Self-Administration of Medication
(Inhaler and Epinephrine Auto-Injector Only)

Student:_________________________________ Birthdate:________________________________

Address:_________________________________ Phone Number: ___________________________

TO:
Principal:____________________________________

School:_____________________________________

The above named student has ____
(Name of disease or allergy)

I am requesting that he/she take the following medication during school hours:

____
Name of medication Dosage Time(s) of administration

Possible side effects could include:____

I certify that ___________________________has been instructed in the use and administration of this medication. (Name of student)

He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency:

Physician printed name:___________________________ Physician phone number:__________________

Physician signature:______________________________ Date:___________________________________

- I authorize my child to possess and self-administer **an epinephrine auto-injector/inhaler** *(circle appropriate selection)* as necessary during school at Newark Grade School District 66.

Parent name and signature____