SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

NURSING & HEALTH SERVICES

School:_____

Phone: _____

Fax:_____

PHYSICIAN'S STATEMENT

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

Student:_____ DOB:_____

Condition(s) for which the medication is being administered:_____

_____

Name of Medication	Dosage	Route of Admin	Time

Do you authorize the student to carry and self-administer the medication without direct supervision? ☐Yes ☐No

Physician's recommendations:_____

_____

_____

_____ _____ _____

Signature of Physician | Medical License # | Date

_____ _____ _____

Printed Name of Physician (or stamp below) | Phone Number | Fax Number