Gates Chili Central School District

PHYSICIAN REQUEST FOR MEDICATION ADMINISTRATION

Name_____ Date of birth_____

Diagnosis_____

Name of Drug_____

Dosage and Frequency_____

Duration of Order_____

Date Order is Effective_____

***For students in grades 6 through 12 ONLY:**

Student is self-directed Yes_____ No_____

Student may self-carry (Albuterol or Epinephrine only) Yes_____ No_____

_____ _____
Signature of prescriber date

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PARENT'S REQUEST

I hereby request that my child _____
be given the medication prescribed above. My child may carry the medication and self-administer, if school rules allow.

_____ _____
Signature of parent/guardian date