San Marcos Unified School District Phone: ______________________

School:____________________________ 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	Method of Administration	Approximate Time of Day
______________________	___________	___________	___________
______________________	___________	___________	___________
______________________	___________	___________	___________
______________________	___________	___________	___________

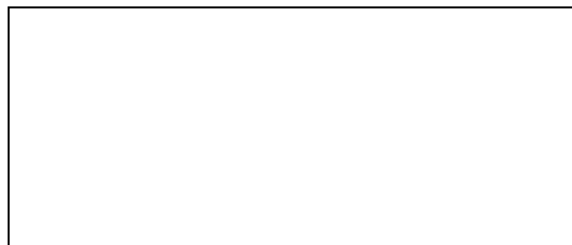
Do you authorize the student to carry and self-administer the medication without direct supervision? ☐Yes ☐No

For Epinephrine auto-injectors, 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



5/2015