

**WARREN COUNTY SCHOOL DISTRICT
HEALTH SERVICES**

**Private Physician Request for Administration of
Medication During School Hours**

Dear Physician:

The parent/guardian of _____, who attends _____ School, has requested that we administer medication(s) to the student during the school day. It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication(s) during school hours, please complete the following information:

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Medication Route: _____

Time Schedule for Administration: _____

Student has demonstrated proficiency in self-administration of their inhaler, Epi-pen/Benadryl, or insulin (age appropriate) and may carry this medication as prescribed above.

Duration of Medication Administration: _____

Possible Side Effects or Contraindications: _____

Curtailment of Specific School Activity (Physical Education, Shop, Lab, etc.) _____

Other Prescribed Medications That the Student is taking outside of school hours: _____

Date: _____

Physician's Name (please print): _____

Physician's Signature: _____

Physician's Business Phone: _____

Per Warren County School District Policy the only medications that may be carried by a student are inhalers, Epi-pens with Benadryl, and insulin (age appropriate).