ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

_____ _____ _____
Name of Student Birth Date ID Number

_____ _____ _____
Address Telephone Number Zip Code

The above named student has _____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

DIASTAT

_____ _____ _____
Name of Medication Type of Medication, i.e. Tablet, Liquid, Inhaler

_____ _____
Dosage Time to be given

_____ Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name _____ **Hospital Affiliation** _____
(Please print or type)

Address _____ **Telephone #** _____ **Fax #** _____

Physician's Signature _____ **Date** _____

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**