SAINT JAMES SCHOOL
ARLINGTON HEIGHTS

PHYSICIAN AUTHORIZATION

SELF CARRY & ADMINISTRATION OF ASTHMA &/OR EPINEPHRINE AUTO-INJECTOR MEDICATION

_____

Name of Student ***Date of Birth***

_____

Address ***Phone Number***

_____

City ***Zip***

The above named student has been diagnosed with_____.

Name of Life Threatening Illness

I am requesting that the above named pupil take the following medication during school hours.

_____

Name of Medication & Dosage

_____

Time(s) to be Self-Administered

_____

Possible Side Effects

I certify that _____has been instructed in the use and

Name of Student

self-administration of_____.

Name of Medication

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

Physician Name _____Phone_____

Physician Signature_____Date_____