# MEDICATION/TREATMENT REQUEST - PHYSICIAN

**Evanston / Skokie**
**SCHOOL DISTRICT 65** **HEALTH SERVICES DEPARTMENT**

Dear Parent or Guardian:

You are required to have your child's doctor complete the form below if:

- you wish school personnel to give over the counter medication
- the school administration requests clarification relating to your child's medication or treatment (example, G-tube feedings)

## TO BE COMPLETED BY YOUR DOCTOR

**I hereby request that:**

**School Personnel administer the following medications/treatment to**

_____
**Name of Child**

| | | | |
|---|---|---|---|
| 1_____ | _____ | _____ | _____ |
| **Medication/Treatment** | **Dosage** | **Time to be given** | **Start & Discontinue Date** |
| 2_____ | _____ | _____ | _____ |
| **Medication/Treatment** | **Dosage** | **Time to be given** | **Start & Discontinue Date** |

**COMMENTS (include clarification as to if/when 911 should be called and possible side effects)**

_____
_____
_____
_____
_____
_____

_____ _____
**Date** **Physician's Signature**

_____
**Physician's Telephone Number**

M-145B