Florence Five District Schools
Johnsonville, SC 29555

Self-Administration of Medication Request Form
(To be completed by physician and parent/guardian)

TO WHOM IT MAY CONCERN:

My Patient, _____, date of birth _____, needs to take the following medicine during the school day. This patient may self-administer this medication.

Medicine:	Dosage:	Time(s) To Be Given:
_____	_____	_____

List any possible adverse reactions this student may have related to this medication.

Medicine:	Reaction(s):
_____	_____
	_____

Date medication to begin:	**Date medication to end:**
_____	_____

Physician's Name: _____

Physician's Telephone Number: _____

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____