OAK GROVE SCHOOL
Where Students Come First
1700 S. O'Plaine Rd, Green Oaks, IL 60048 • (847) 367.4120 • www.ogschool.org

Physician Request for Self-Administration

_____ _____
Name of Student Date of Birth

The above named student has _____
(Name of Disease or Syndrome)

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

_____ _____
Name of Medication Type of Medication (oral, inhaler, etc)

_____ _____
Dosage Times to be given

_____
Possible Side Effects

I certify that _____ has been instructed in the use and self-
Student name

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 am be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____ _____
Signature of Physician Date Phone Number

_____ _____
Print Name of Physician Address of Physician