San Marcos Unified School District **Phone (760) ____________**

School: ______________________ **Fax (760) ____________**

PHYSICIAN'S STATEMENT

Name of Pupil________________________________ Birth date____________

Last First MI Month / Day / Year

1. Name of Medication	Dosage	Method of Administration	Approximate Time of Day
____________________	__________	__________	__________
____________________	__________	__________	__________

2. Discontinue medication #1 on _______________ and #2 on ________________

3. Type of assistance for administering medication (observe, measure, etc.)__________

____

4. Precautions for administration or storage of medication_______________________

____

5. For inhalants, do you feel that the student can carry and self-administer the inhaler without direct supervision? Yes___No___

6. Do you wish to have school personnel contact you at intervals to discuss this medication? Yes___No___

Please indicate______________________________ Interval______________

Nurse, Teacher, Psychologist, etc. Weekly, Monthly, Quarterly

________________________	________________	________________
Printed Name of Physician	Medical License #	Telephone Number
________________________	________________	________________
Signature of Physician	Date	Fax Number