Rancho Santa Fe School
Physician's Statement
Valid for the 2016-2017 School Year

Name of Pupil: _____ _____
Last First Date of Birth

Teacher: _____ Grade: _____ Room # :_____

This portion is to be completed by a physician licensed in the State of California:

- List the condition(s) for which the medication is to be given:

_____

- List indication/signs and symptoms for administering the medication:

_____

Name of Medication	Dose	Route	Frequency
1.			
2.			
3.			

Discontinue Medication #1 on _____
Date

Discontinue Medication #2 on _____
Date

- Type of assistance needed for administering medication (i.e. observe, measure, etc.)

_____

- Precautions for administration or storage of medication:

_____

_____ _____
Physician Name/License Number Phone Number

_____ _____
Physician Signature Date