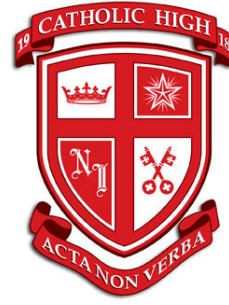


CATHOLIC HIGH SCHOOL



PHYSICIAN FORM

ADMINISTERING OF MEDICATION

TO BE COMPLETED BY LICENSED PHYSICIAN OR DENTIST:

I hereby certify that it is medically necessary for _____ to receive medication during school hours. (Student's name)

1) Diagnosis: _____

2) Medication to be administered: _____

3) Dosage: _____

4) Time of day to be administered: _____

5) Duration of medication order: _____

6) Possible side effects of the medication: _____

7) Any contra-indication for administering medication: _____

(Physician's signature)

(Date)

Print Name of Physician

Physician Office Number

This form may be faxed to the school : (337) 364-5041

1301 DE LA SALLE DRIVE - NEW IBERIA, LOUISIANA 70560 - (337)364-5116