File: JHCD-E

TIFFIN CITY SCHOOLS
PHYSICIAN'S VERIFICATION STATEMENT

Please print or type the following information:

Name of Student _____

Address _____

_____

School _____

Grade _____

Name of drug to be administered _____

Dosage _____

Time drug is to be administered _____

Dates when administration should begin and end:
Beginning Date _____
Ending Date _____

Severe reactions that should be reported to physician:

_____

_____

Special instructions, if any _____

_____

Name of Physician _____

Address _____

Phone Number _____

Physician's Signature _____

Date _____