PHYSICIAN'S STATEMENT

If your child has a medical diagnosis, this form must be completed by your child's physician.

Date: _____

Child's Name: _____

Physician's Name: _____

Current Medical Diagnosis(ses): _____

_____

Current Medication(s): _____

_____

Dosage: _____

_____

Time(s) to be administered: _____

_____

Possible side effects: _____

_____

Termination date for administering medication: _____

PLEASE SIGN AND DATE THIS FORM AND RETURN TO:

Miriam School
501 Bacon Avenue
St. Louis, MO 63119
Phone: 314-968-5225
Fax: 314-968-7338

_____
Signature of Prescribing Physician