PHYSICIAN STATEMENT

To the Physician:

The Greenspire School requires that all of the following information be provided before it will administer medication or treatment to the student.

_____ _____

Name of Student Address

The Greenspire School

_____ _____

School Grade

I have prescribed the following medication[s]:

Medication[s]:	Dosage:	Instructions and Precautions:

Physician's Signature: _____Telephone: _____

Printed/Typed Name: _____Date: _____

KINDLY EMAIL OR FAX THIS FORM BACK TO THE GREENSPIRE SCHOOL

Fax: 866-805-1327

office@greenspireschool.org