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 completed form and return to:

Miriam Academy, 2845 N. Ballas Road, St. Louis, MO 63131

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Signature of Prescribing Physician