Exhibit **Descriptor Code: JGCD~E (2)**
Medicines

PHYSICIAN'S STATEMENT

Date _____

Name of Pupil _____

Name of Medication _____

Dosage _____

Time medication is to be given during the school day _____

Expected duration of administration of medication _____

Possible side effects _____

_____

_____

Physician's Signature _____

Print Physician's Name _____

Physician's Address _____

Physician's (City, State, Zip) _____

Physician's Phone Number _____

ISSUED: 09/11/2000

DEKALB COUNTY BOARD OF EDUCATION