PHYSICIAN/PHARMACIST DRUG USE STATEMENT

Name of Employee: ____

Date of Notification: ________________________

1. Type of Drug

   _______ Prescription

   _______ Non-Prescription (over-the-counter)

2. Name of drug(s) ____

   ____

3. Is this drug taken on a regular basis?

   ______ Yes ______ No

4. What affect will this drug have on the above named person's ability to safely operate a school bus?

   ____

   ____

   ____

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____ ____________

Signature of Physician/Pharmacist **Date**

____ ____________

Signature of Employee **Date**

ISSUED 05/25/95