

**THE SOUTH CAMPUS
909 E. WILMETTE
PALATINE, IL 60074
(847) 359-8300
(847) 359-8301 fax**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

PARENT PERMISSION:

DATE: _____

Student's Name _____

Birthdate: _____

Address: _____

School: _____

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

S/He is also taking the following medications (please write dosage & times taken):

I give permission to the school nurse or authorized school personnel to administer the medication identified to the above-named student.

Parent/Guardian
Signature: _____

Phone: Home: _____ Work: _____

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PHYSICIAN'S ORDERS:

Medication: _____ Dose: _____ Times: _____

Medication: _____ Dose: _____ Times: _____

Duration: From: _____ To: _____

Condition Requiring Medication: _____

Possible Side Effects: _____

I hereby request that the school nurse or authorized personnel administer the above prescribed medication, as it is medically necessary to do so during school hours.

Physician's Signature: _____

Date: _____

Phone: _____