



865 E. Wilmette Road, Palatine, IL 60074 Phone: 847-359-8690 Fax: 847-359-8691

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL
2011-2012 School Year

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: _____ Time: _____
Time: _____

Medication: _____ Dose: _____ Time: _____
Time: _____

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: _____