



Authorization for Administration of Medication at School

Physician Request

Date

Student Name Birth Date

Medication

Dose Time

Duration: From To
Date Date

Indicate why medication is required during regular school hours in order to maintain the continued attendance of this student.

Condition requiring medication

Desired benefits of the medication

Indicate any expected reactions

Indicate how school personnel can determine if student experiences an adverse reaction

Indicate steps for school personnel to follow in case student experiences an adverse reaction to the medication

This medication may be self-administered Yes No

This medication may be administered by authorized school personnel Yes No

*The student should retain the prescribed medication on his/her person at all times due to need for immediate administration in the event of an emergency Yes No

I hereby request that the above medication be administered during school hours and certify that it is absolutely medically necessary to maintain the continued attendance of the student.

Physician Signature Date
Physician or other licensed health care provider who is authorized to prescribe medication under Illinois Law

Phone Fax

*Medications prescribed on an "as needed" basis will be considered to be administered on an emergency basis.