"EMPOWERING ALL LEARNERS TO SUCCEED IN THEIR WORLD"

Administration Offices
245 West Exchange Street
Sycamore, Illinois 60178

syc427.org

Kathy Countryman, Ed.S.
Superintendent
815-899-8103
fax: 815-899-8110

Nicole Stuckert
CFO/CSBO
815-899-8100
fax: 815-899-8119

Kristine Webster, Ed.D.
Director of Curriculum
815-899-8244
fax: 815-899-8127

Lynn Reilley
Director of Special Education
815-899-8117
fax: 815-899-8127

MEDICATION/PROCEDURE PERMISSION FORM

Student ________________________________ Birthdate __________________

School ______________Grade______________ Teacher ___________________

Parent/Guardian ____

Address _________________________________Phone_____________________

Diagnosis ____

Name of Medication/Procedure

____

____

Dose ____________________________ Time ____________________________

Special Instructions (as needed) _____________________________________

____

Is this medication necessary to maintain the child in school? _______________

Possible side effects ____

_____________________________   ___________________________
Physician Signature   Printed Name

_____________________________   ___________________________
Physician Address   Phone Number

PARENT PERMISSION

I hereby authorize the designated staff person to administer the above prescribed medication/procedure or supervise the student in self-administration according to the directions. I acknowledge and agree that, when the lawfully prescribed medication/procedure is so administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication described above.

Signature of parent/guardian_______________________ Date _____________

I hereby grant permission for the school nurse to exchange information with the treating physician regarding medication administered to my child at school.

Signature of parent/guardian_______________________ Date _____________