Sycamore Community
School District 427

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 _____