



Permission to Administer Medication (Prescription & Non-Prescription)

Complete this form so the nurse can administer medication(s) during school hours, provided by you, to your child as needed. Submit the form, along with the medication(s) in original packaging and with label intact and expiration date, to the health office. The form will be kept on file for the current school year only. **You must complete a separate form for each medication.** Contact the nurse with questions.

School Fax Numbers:

Caruso: 847-945-1963

South Park: 847-945-529

Wilmot: 847-405-9736

Shepard: 847-948-8589

Kipling: 847-948-8264

Walden: 847-945-0035

School: ☐ Caruso ☐ Shepard ☐ Kipling ☐ South Park ☐ Walden ☐ Wilmot

Student Name: _____ Date of Birth: _____

Address: _____

Parent Phone Number: _____ Parent Email: _____

Condition, Disease, or Illness for Which Medication is Prescribed: _____

Medication: _____ Dose: _____ Route: _____

Administration Time/Instructions: _____

Possible Side Effects: _____

Other Medication Prescribed for Student: _____

Potential Drug Interactions: _____

For self-administered medication such as epi pens and inhalers physician must initial below:

____ Student may carry this medication on his/her person.

____ Student is capable of self-administration and has been instructed in the proper technique of administration.

It is strongly recommended that "back up" medication be kept in health office.

PHYSICIAN SIGNATURE/PARENT CONSENT TO ADMINISTER ABOVE MEDICATION

Print Physician Name: _____ Physician Phone: _____

Physician Address: _____ Physician Fax: _____

Physician Signature: _____ Date: _____

I give permission for my child/ward _____, to receive the above medication as prescribed. I understand that my signature on this form constitutes a waiver by me to the school staff member administering or supervising administration of this medicine for liability for untoward reactions when the medicine is administered in accordance with the licensed prescriber's instructions. I also understand that my signature on this form denotes permission for the nursing personnel and the licensed prescriber to confer regarding the administration/monitoring of this medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian's Emergency Phone Number(s) _____