

SCHOOL MEDICATION PERMISSION

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student's Name: _____ Grade _____ Birthdate _____

Address: _____ Home Phone: _____

Emergency Contact: _____ Phone: _____

I grant permission to _____ school district employees to administer/supervise the medication routine described below under the Guidelines for Administration of Medication in my school district.

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN:

Name of medication: _____ Date of Prescription: _____

Dosage and directions: _____

Diagnosis: _____

Side effects of this medicine include: _____

Reasons Medication must be given during school hours: _____

Student may self administer with supervision with the following instructions:

Physician Signature Date

ABC Pediatrics, Ltd.

Gus A. Rousonelos, MD Erin L. Shanks, MD
Karolyn D. Law, MD Ushma Patel, MD
Pamela M. Persak, MD

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(630) 355-0003

Any questions, please call our office.

Approved by the certified school nurse to begin administration on: _____

Certified School Nurse Signature Date