

MEDICATION AUTHORIZATION FORM

_____ SCHOOL, _____, ILLINOIS

Student's Name (Last, First, Middle) Date of Birth Grade Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned the following to the School Principal or his/her designee:

- X Medical Authorization Form
- X Unsupervised Self-Administration Request Form (if the student is to carry and use medication on his/her own during school hours or during school activities)
- X Medication in the original labeled container as dispensed (Prescription medication) or the manufacturer's labeled container (Non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Physician's Order

Medication/ Health Care Treatment Dosage Time(s) to be administered

Intended effect of this medication Expected side effects, if any

Other medications the student is taking

May student self-administer medication under supervision of school personnel who do not have medical training?

(Please circle) YES NO

Administration Instructions

Discontinue Re-evaluation Follow-up (Please Circle): _____
Date

Physician's /Prescriber's Signature Date Signed

Physician's/ Prescriber's Name Emergency telephone number

Address City , State, Zip Code