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

All About Kids Pediatrics
Doris Nietert, MD

1250 North Mill St
Suite 100
Naperville, IL 60563
630-355-6996

Any questions, please call our office.
Approved by the certified school nurse to begin administration on:_____

_____ __ _____
Certified School Nurse Signature Date