Waukegan Public Schools Office of School Health Services

AUTHORIZATION OF THE ADMINISTRATION/ SELF ADMINISTRATION OF MEDICATION

				
Student's Name	Date of Bir			eacher
TO BE COMPLETED BY THE APPR				
PLEASE NOTE: Only those medicines which of absolu	-	-	_	n at school: once a
day, twice a day, and three times a day medicines wi	<u>II not be given at schoo</u>	oi uniess s	pecifically request.	
Medication	Dos	age	Time of Administration	Route
Prescribed for (diagnosis)				
Reason for Medication (intended effects)				
Restriction and/or Side Effects: () Yes (pl	ease describe below	<i>'</i>) ()	None anticipated	
This student is both capable and responsible for () No () Yes- Supervised () Yes	_	is medic	ation:	
For Asthma Inhaler or Epi-pen only: This student may carry this medication: () No	()Yes - if	yes com	plete the following	
I certify thathas	been instructed in the	he use a	nd self-administration	
Name of Student				
of				
Name of the permitted to self administer this medication, he	of Medication	o nood fo	r the medication, and the	nocossity to ropor
to school personnel any unusual side effects. He				
		ogo		, -
Other prescription and non-prescription medicati				
I may be reached at the following phone # in the	event of a reaction to	o the me	dication or an emergency	:
Signature of Medical Provider	Date	Printed I	Name of Medical Provider	
			·	
Medical Provider Phone #		Med	ical Provider Fax #	
Medical Provider Address				
TO BE COMPLETED BY PARENT / GUARDIAN				
I give permission for my child		to re	ceive the above medicati	on as prescribed.
understand that my signature on the form constit				
administering or supervising administration of thi				
administered in accord with the prescribing State				
indemnify and hold harmless the school district, in medication by or to my child in accordance with it				
misconduct. I consent to the sharing of informati				
and an executed authorization form is attached h				,,
Date Parent/Guardian's signa	uture		Daytime F	Phone #
F-311 (04/14)E			·	