NORTHERN SUBURBAN SPECIAL EDUCATION DISTRICT
760 Red Oak Lane Highland Park, IL 60035
Phone: 847-831-5100 Fax: 847-278-0087

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Student's Name: _____ Birth Date: _____

School: _____ School Year (including ESY): _____

WRITTEN ORDER AND PERMIT TO ADMINISTER PRESCRIPTION, OTC NON-PRESCRIPTION MEDICATION, VITAMINS AND HERBALS DURING SCHOOL HOURS

Name of Medication: _____ Dosage: _____

Route of Administration: _____

Frequency and Time of Administration: _____

Diagnosis Requiring Medication: _____

Intended Effects of Medication: _____

Side Effects of Medication: _____

Other Medications Student Receives:

_____

Printed Name of Physician: _____ Date: _____

Signature of Physician: _____

Physician's Address: _____

Physician's Phone: _____ Physician's FAX: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and grant permission for Northern Suburban Special Education District to administer, or supervise the self-administration of medication to my son/daughter, _____, according to the above instructions. I further waive any claims against the District, members of its Board, its employees, and agents, either jointly or severally, from and against any and all liability, claims, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration of said medication.

I, _____, give permission for my child to receive the above medication(s) as directed by the physician. I will provide all supplies needed to do the procedure. I will notify the school in writing if the medication is discontinued.

Parent's Signature: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Submit