

DEERFIELD PUBLIC SCHOOLS

District 109

517 Deerfield Road • Deerfield Illinois 60015-4498

Phone: (847)945-1844 • Fax: (847)945-1853

PERMISSION TO ADMINISTER MEDICATION

Medication MUST be labeled by physician or pharmacist

Student's Name: _____ Date of Birth: _____

Grade: _____ School: _____

Date of Prescription: _____ Discontinuation Date: _____

Disease or illness: _____

Medication: _____

Reason for medication to be given during school hours: _____

Daily: _____ PRN: _____ Emergency: _____

Strength: _____ Dosage: _____ Time: _____ Frequency: _____

Route of administration: _____

Condition under which it should be given: _____

Intended effect of medication: _____

Side effects (from medication) that student should be observed for: _____

Other medication child is receiving: _____

Re-evaluation date: _____

May Student self-administer medication under supervision of Health Service personnel? Yes or No

Directions for self-administering: _____

May Health Service Personnel administer medication? Yes or No

Severity of asthma necessitates the student carry inhaler on his/her person while in school? Yes or No

Severity of allergy necessitates that student carry Epi Pen on his/her person while in school? Yes or No

Should an additional Epi Pen be kept in the Health Office? Yes or No

Any additional instructions from Physician? _____

Consent of Parent or Guardian to Administer Above Medication

Print Physician's name & phone number _____

Physician's signature _____

Date: _____

Parent or Guardian's signature _____

Parent or Guardian's emergency phone number _____

Date _____