



Adlai E. Stevenson High School
Permission Form to Administer Medication
(PRESCRIPTION AND/OR OVER-THE-COUNTER)

STUDENT'S NAME: _____ ID #: _____ DATE OF BIRTH: _____

MEDICATION WILL NOT BE ADMINISTERED UNTIL A LICENSED PROVIDER AND PARENT/GUARDIAN COMPLETES AND SIGNS THIS FORM.

STEP 1: TO BE COMPLETED BY LICENSED PRESCRIBER

Medications (prescription/over-the-counter), which are necessary during the school day, will be administered during school hours. I hereby authorize the nursing personnel of Stevenson High School District 125 to act on my behalf in administering the following medication(s) during school hours.

Name of Medication _____

Reason for Medication _____

Possible Side Effects _____

Dosage Prescribed _____

Time of Administration _____

FOR ASTHMA, ALLERGY OR DIABETIC MEDICATION ONLY (Inhalers, Epi-Pen, Insulin)

1. Student may carry medication on his/her person YES No
2. Student may self-administer medication YES No
3. Directions for self-administration _____

Note: We recommend that "back-up" medication be stored in the Nurse's office as well.

LICENSED PRESCRIBER'S INFORMATION

Printed Name: _____

Address: _____

Phone: _____ **Fax:** _____

X _____
Signature **Date**

STEP 2: TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child/ward _____, to receive the above medication as prescribed. I understand that my signature on this form constitutes a waiver by me to the school staff member administering or supervising administration of this medicine for liability for untoward reactions when the medicine is administered in accordance with the licensed prescriber's instructions. I also understand that my signature on this form denotes permission for the nursing personnel and the licensed prescriber to confer regarding the administration/monitoring of this medication.

Please note: Medication must be brought to school by the parent. It is your child's/ward's responsibility to present himself/herself to the office at the appropriate time for medication.

Medication prescribed and/or over-the-counter cannot be given unless the licensed prescriber completes this form in its entirety and is signed by the parent/guardian.

X _____
Parent/Guardian Signature **Daytime Phone Number** **Date**



East Nurse's Office
West Nurse's Office

847-415-4019
847-415-4025

Fax: 847-634-2905
Fax: 847-634-2902