COMMUNITY HIGH SCHOOL DISTRICT 94
SCHOOL MEDICATION AUTHORIZATION FORM

Phone: (630) 876-6245
Fax: (630) 876-6585

THIS FORM IS REQUIRED IF YOUR CHILD IS TO RECEIVE <u>NON-PRESCRIPTION AND/OR PRESCRIPTION MEDICATION</u> AT SCHOOL <u>AND/OR</u> CARRY AN INHALER OR EPI-PEN.

STUDENT'S NAME:_____ STUDENT ID#:_____ DOB:_____

DIAGNOSIS:_____

PHYSICIANS: Please Complete diagnosis (above), items 1 and 2, and sign and date this form.

1. List all medication prescribed to this student:

DRUG	DOSAGE	FREQUENCY	REASON PRESCRIBED	WHEN RE-EVALUATION PLANNED	SIDE EFFECTS

2. List medication that must be administered during <u>School Hours.</u>

DRUG	DOSAGE	TIME TO BE ADMINISTERED	REASON PRESCRIBED	SIDE EFFECTS	SPECIAL INSTRUCTIONS

Permission is granted for professional school personnel to administer drugs as prescribed during the school day. Medication will be provided by the parent as instructed. **If the medication prescribed (inhaler or Epi-Pen only)** is to be self-administered by the student, I certify that _____ has been instructed in the use and
(Name of Student)
self-administration of _____ . He/she understands the need for the medication, and the
(Name of Medication)
necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PRINTED NAME OF PHYSICIAN: _____ PHONE NUMBER: _____