ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone	Zip Code

I _____ (Mother, Father, Legal Guardian) of the above named student, give permission to the school nurse to administer medication as requested by my child's physician _____ during school hours.

NAME OF PHYSICIAN

I will bring the medication to school nurse or principal/designee in original container appropriately labeled by the pharmacist or licensed provider.

_____
Signature of Parent / Guardian

_____
Address

_____
City Zip

_____
Home Phone Business Phone

_____
Date

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

Rev 1/19

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PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has _____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler
Dosage	Route	Time to be given

_____
Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____**Date** _____

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