CICERO SCHOOL DISTRICT 99

5110 WEST 24th STREET CICERO, ILLINOIS 60804
Tel. (708) 863-4856 Fax (708) 863-1065

SCHOOL MEDICATION AUTHORIZATION FORM

A new form is required for each school year and for any change in the medication, dose or frequency.

Name______________________________ Birthdate______________ Homeroom________

I have read the Medication in School policy and give permission for my child to receive the medication(s) prescribed by my doctor during school hours. I understand that I must promptly notify the school district of changes in the medication, dosage or frequency and provide refills of the medication as needed.

____ ____________________
Parent/Guardian Signature Date

My child **WILL/WILL NOT** be self-administering their **Epi-Pen/Asthma** medications.

____ ____________________
Parent/Guardian Signature Date

---------------------------TO BE COMPLETED BY THE PHYSICIAN-------------------------------

Dear Doctor,
Please provide the information below along with any special precautions or indications for this child to receive a medication during school hours.

Medication name, dosage and frequency:____
Purpose of the medication:____
Potential side effects:____
Other prescription or OTC medications used by this student:___________________________
Will this medication need to be taken with the student on any field trips:________________
Student allergies:____
Please provide any additional information regarding emergency care, specific safety information, signs and symptoms of potential adverse reactions:_____________________________________

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____ _________________ ____________
Physician's Signature/Printed Name Telephone Number Date