

To be updated by parent/guardian/physician annually

Physician's Order

Student _____

Grade _____

Medication/ Health Care Treatment

Dosage

Time(s) to be administered

Intended effect of this medication

Expected side effects, if any

Other medications the student is taking

- 1) May student self-administer medication under supervision of school personnel who do not have medical training?

(Please circle) YES NO

- 2) For ASTHMA and ALLERGY CONDITIONS ONLY:

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

Physician's /Prescriber's Signature

Date Signed

Physician's/ Prescriber's Name (PRINT)

Emergency telephone number

Address

City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____,
(Please circle one)

20 ____, by _____ on behalf of
Signature of Principal

_____, School, _____, Illinois