Last Name, First Name, MI

Grade

FOR OFFICE USE ONLY

Medical Information and Emergency Notification Form

Academic Year _____

_____ _____

Student's name (Last Name, First Name, Middle Initial) Date of Birth

I hereby acknowledge that I have received and read the School Medication Procedures. I understand that I am primarily responsible for all medical decisions regarding my child and that under the School Medication Procedures, and that the administration or self-administration of medication to my child will not be allowed unless I have complied with the requirements of the School Medication Procedures.

_____ has the following medical conditions:
(Student's name)

_____

_____

In case of an emergency involving this student, please contact:

_____ _____

Parent or Guardian Daytime telephone

_____

Other telephone

Other Emergency Contact:

_____ _____

Individual Daytime telephone

_____ _____

Relationship to Student Other telephone

X_____ _____

Signature of Parent/Guardian Date

MEDICATION AUTHORIZATION FORM

_____ SCHOOL, _____, ILLINOIS

Student's Name (Last, First, Middle	Date of Birth	Grade	Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned the following to the School Principal or his/her designee:

X Medical Authorization Form

X Unsupervised Self-Administration Request Form (if the student is to carry and use medication on his/her own during school hours or during school activities)

X Medication in the original labeled container as dispensed (Prescription medication) or the manufacturer's labeled container (Non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Physician's Order

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

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

(Please circle) YES NO

Administration Instructions

Discontinue Re-evaluation Follow-up (Please Circle): _____ Date

Physician's /Prescriber's Signature

Date Signed

Physician's/ Prescriber's Name

Emergency telephone number

Address

City , State, Zip Code

(SIDE 1)