

COMMUNITY UNIT SCHOOL DISTRICT NO. 220  
310 E. James Street, Barrington, Illinois 60010

REQUEST FOR ADMINISTRATION OF MEDICATION

**To Be Completed By Licensed Prescriber**

When it is necessary for a student to receive medication at school, the following information must be provided:

\_\_\_\_\_ (Student's name) \_\_\_\_\_ (Date of birth) \_\_\_\_\_ (grade/rm)

Should take \_\_\_\_\_ (Name of Medication) \_\_\_\_\_ (dosage)

At \_\_\_\_\_ (time of day) by \_\_\_\_\_ (route) for \_\_\_\_\_ (period of time)

Diagnosis of disease or injury \_\_\_\_\_

Desired benefits of medication \_\_\_\_\_

Medication side effects \_\_\_\_\_

Other medication student is receiving \_\_\_\_\_

Doctor's name printed \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ Fax Number \_\_\_\_\_

Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_

NOTE: The "Request For Self-Administration of Emergency Medication" form must be completed if medication request is for the self-administration of asthma medication or Epi-Pen.

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**To Be Completed By Parent/Guardian**

I give permission for my child \_\_\_\_\_ to receive the above medication as prescribed. I agree to the terms of the procedures for the administration of medication. I further completely release Community Unit School District 220 and its employees and agents of any liability or obligation of any nature in any way related to the District medication policy and procedure. I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration/monitoring of this medication.

\_\_\_\_\_ Parent or Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**Medication Must Be Brought To School By The Parent/Guardian!**