Community Unit School District No. 220, 310 E. James Street, Barrington, IL 60010

REQUEST FOR ADMINISTRATION OF MEDICATION FOR ENVIRONMENTAL EDUCATION

To The Licensed Prescriber

When it is necessary for a student to receive medication at school, the following information must be provided. Please complete one section for each medication. See reverse.

_____ _____

(Student's name) (Date of birth)

****

Name of Medication _____

Dosage _____ Times Taken _____

Route _____ Period of Time _____

Diagnosis of disease or injury _____

Desired benefits of medication _____

Possible side effects _____

Other medication student is receiving _____

For Asthma Medication or Epi Pen Only

Self-Administered (pupil has the discretion as to the use)

( ) Yes

- I certify the student has been instructed in the use & self-administration of this medication.
- Under what circumstance _____

( ) No

****

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****

Doctor's name printed _____ Phone # _____

Address _____ Fax # _____

Doctor's signature: _____ Date _____

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. CUSD #220 and its employees and agents incur no liability (except for willful and wanton conduct) as a result of any injury arising from the pupil's self-administration of asthma / emergency medication. 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 Emergency Cell Phone #

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(Student's name) (Date of birth)

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Route ______________ Period of Time ______________
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