

Request for Administration of Medication Health Services

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|---|---|---|---|
| <input type="checkbox"/> Chesak Elementary
(847) 659-5704
(847) 659-5720 – Fax | <input type="checkbox"/> Conley Elementary
(847) 659-3704
(847) 659-3720 – Fax | <input type="checkbox"/> Heineman M.S.
(847) 659-4304
(847) 659-4320 – Fax | <input type="checkbox"/> Huntley H.S.
(847) 659-6604
(847) 659-6520 – Fax |
| <input type="checkbox"/> Leggee Elementary
(847) 659-6204
(847) 659-6220 – Fax | <input type="checkbox"/> Mackeben Elementary
(847) 659-3404
(847) 659-3420 – Fax | <input type="checkbox"/> Marlowe M.S.
(847) 659-4704
(847) 659-4720 – Fax | <input type="checkbox"/> Martin Elementary
(847) 659-5306
(847) 659-5320 – Fax |

Documentation from the parent and physician for the administration of all medications (including over-the-counter medications) must be on file at the school. **ALL** medications must be brought to the school office by a parent or other responsible adult. In addition, **prescription medications** must be contained in the original prescription bottle as labeled by the pharmacy. **Non-prescription medications** must also be contained in the original packaging clearly labeled with the child's name.

This form must be completed, signed by the parent and physician, and submitted to the school office on an annual basis, at the beginning of each school year, or as the need for the administration of medication becomes necessary.

Student's Name: _____ Birth Date: _____ Grade: _____
Please Print

Prescription Medication
 Non-Prescription Medication Name of Medication: _____

Dosage: _____ Frequency: _____

Time(s) to Be Given: _____ Duration: _____

Possible Side Affects: _____

Prescription Medication
 Non-Prescription Medication Name of Medication: _____

Dosage: _____ Frequency: _____

Time(s) to Be Given: _____ Duration: _____

Possible Side Affects: _____

Name of Physician: _____ Phone Number: _____
Please Print

Address: _____

Signature of Physician Date

I authorize Huntley School District 158 and its employees and agents, to administer the above medication(s) as directed by the physician. The appropriately labeled medication will be brought to the school by me or another responsible adult. I agree to provide written notification by the physician if the dosage is changed or if the medication is discontinued. I also give my permission to Huntley School District 158 and its employees and agents, to contact the physician in regard to any medication questions or concerns.

Parent's Name: _____ Relationship: _____
Please Print

Home Phone: _____ Work Phone: _____ Cell: _____

Signature of Parent Date