

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 ASTEMA 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

_____, Illinois School, _____