

CHARLESTON COMMUNITY UNIT SCHOOL DISTRICT NO. 1
School Health Office
Phone: 639-5015 Fax: 639-5005
ADMINISTRATION OF MEDICATION

STUDENT'S NAME _____

SCHOOL _____

Age _____ Grade _____ Teacher _____

TO BE COMPLETED (IN FULL) BY PHYSICIAN:

Name of drug to be given _____**Number of hours between doses** _____ **If as needed, please indicate** _____**Dosage to be given at school** _____**Frequency/Time of Administration to be given at school** _____**Disease or illness of student** _____**Action of the drug** _____**Side effects of the drug** _____**This drug is to be given until what date?** _____**Can the student carry his/her inhaler?** _____ **Yes** _____ **No**_____
Parent's Signature_____
Doctor's Signature_____
Address_____
Address_____
Telephone Number_____
Telephone Number_____
Date_____
Date

By signing this, I, the parent, understand that I am releasing Community Unit School District #1 and the employees of any liability while following the above request.

When a Certified School Nurse or Administrator is not available, (school employees) i.e. licensed practical nurses, secretaries, aides, etc. may be the persons giving your child his/her medication.

Permission granted for this request by _____
 (School Personnel)

******The above named medication is to be brought to school in a container appropriately labeled by the pharmacy or physician. Sample medication or over the counter medications can be labeled by the parent(s). This container must duplicate the directions given on this request.**