SCHOOL MEDICATION PERMISSION
NAPERVILLE SCHOOL DISTRICT 203

STUDENT'S NAME: _____ GRADE: _____
BIRTHDATE:_____

ADDRESS: _____ PHONE: _____ SCHOOL: _____

I hereby request that Naperville School District 203 employees administer or supervise the administration of medication in accordance with the routine described under the Guidelines for the Administration of Medication in Naperville School District 203.

I hereby release Naperville Community Unit School District 203 and any of its agents, employees administrators or other parties (hereinafter, the "District") from any liability for any injury or harm which is suffered by _____ _____ as a result of our District's agreement to honor this request. I agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

_____
PARENT/GUARDIAN SIGNATURE DATE

TO BE COMPLETED BY THE PHYSICIAN:

DIAGNOSIS: _____ MEDICATION: _____

ROUTE OF ADMINISTRATION: _____ DOSAGE: _____ TIME: _____

SIDE EFFECTS: _____

DATE OF PRESCRIPTION: _____ DISCONTINUATION DATE: _____

THE STUDENTS WILL SELF-ADMINISTER MEDICATIONS IN THE SCHOOL HEALTH OFFICE WITH SUPERVISION OR THE MEDICATION MAY BE ADMINISTERED BY A DISTRICT STAFF MEMBER. THE FOLLOWING DESCRIBES THE CIRCUMSTANCES WHICH INDICATE THAT MEDICATION SHOULD BE ADMINISTERED:

_____

_____

OTHER MEDICATION STUDENT IS RECEIVING:

_____

_____
ANNUAL REEVALUATION/PERMISSION IS REQUIRED. INDICATE IF IT SHOULD BE SOONER:

_____
PHYSICIAN'S SIGNATURE/LICENSED PRESCRIBER'S NAME DATE OFFICE PHONE #

9/02 (40-3)