BERWYN SOUTH SCHOOL DISTRICT 100
3401 South Gunderson Avenue
Berwyn, Illinois 60402
(708) 795-2300
FAX (708) 795-2317

PERMISSION FORM FOR PRESCRIBED MEDICATION

School _____ Date form received by the school: _____

Student: _____ Date of birth, or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Reason for medication: _____

Name of Medication: _____

Form of medication/treatment:

___ Tablet/capsule ___ Liquid ___ Inhaler ___ Injection ___ Nebulizer ___ Other

Instructions (Schedule and dose to be given at school):

Start: _____ date form received _____ Other date: _____

Stop: _____ end of school year _____ Other date/duration: _____

For episodic/emergency events only _____

Restrictions and/or important side effects: ___ None anticipated

☐ Yes. Please describe:

Special storage requirements: ___ None ___ Refrigerate

Other:

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes-Supervised ☐ Yes-Unsupervised

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

___ On the back side of this form ___ as an attachment

DATE: _____ SIGNATURE:

Physician's Name: _____

Address: _____ Phone No.:_____

To the school: Please report concerns about medication or disease to the above physician.

To be completed by parent/guardian

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy.

Date: _____ Signature: _____ Relationship: