STUDENT MEDICATION FORM
(PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE R.N.)

TO: Building Nurse
Indian Prairie Community Unit
School District No. 204
P.O. Box 3990
Naperville, Illinois 60567

The following student is presently under my care for asthma or other illness. I believe that the failure of the student to receive the medication referenced herein, which I have prescribed, during the school day would jeopardize the student's heath and education. Where applicable, information relating to the student's self-administration of the medication referenced herein, which I have prescribed, is set forth below.

Student's Name:____________________________________ Birth Date:

Student's Address:__________________________________ Phone No.:

School Attended:___________________________________ Grade:

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Name of Medication:

Dosage of Medication:

Purpose of Medication:

Illness or Disease Identified (or Diagnosed):

Possible Side Effects:

Time or times at which, or special circumstances under which, the medication is to be administered:

____
Signature of Physician/Provider Date

____
Name of Physician/Provider

____
Street Address

____
City/State Zip Code

____
Office Phone No.

____
Emergency Phone No.