

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 NUMBER

(Copy on Pink)

**SCHOOL MEDICATION PERMISSION  
FOR LIFE THREATENING CONDITIONS  
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 below and under the Guidelines for 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/NAME OF ALLERGEN: \_\_\_\_\_ MEDICATION: \_\_\_\_\_

ROUTE OF ADMINISTRATION: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ TIME: \_\_\_\_\_

SIDE EFFECTS: \_\_\_\_\_

DATE OF PRESCRIPTION: \_\_\_\_\_ DISCONTINUATION DATE: \_\_\_\_\_

The student may self-administer emergency 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.

Please check one box only

Administer Epi-pen immediately for **suspected** exposure:

Administer Benadryl \_\_\_\_\_, for suspected  
(mg) exposure, and Epi-pen if symptomatic

Administer Epi-pen when symptomatic- no Benadryl:

OTHER MEDICATION STUDENT IS RECEIVING: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE/LICENSED PRESCRIBER'S NAME DATE OFFICE PHONE NUMBER