

To be updated by parent/guardian/physician annually

Physician's Order

Student \_\_\_\_\_

Grade \_\_\_\_\_

Medication/ Health Care Treatment \_\_\_\_\_

Dosage \_\_\_\_\_

Time(s) to be administered \_\_\_\_\_

Intended effect of this medication \_\_\_\_\_

Expected side effects, if any \_\_\_\_\_

Other medications the student is taking \_\_\_\_\_

- 1) May student self-administer medication under supervision of school personnel who do not have medical training?

(Please circle) YES NO

- 2) For ASTHMA and ALLERGY CONDITIONS ONLY:

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

Physician's /Prescriber's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Physician's/ Prescriber's Name (PRINT) \_\_\_\_\_

Emergency telephone number \_\_\_\_\_

Address \_\_\_\_\_

City , State, Zip Code \_\_\_\_\_

Medication Authorization approved or denied and signed this \_\_\_\_ day of \_\_\_\_\_,  
(Please circle one)

20 \_\_, by \_\_\_\_\_ on behalf of  
Signature of Principal

\_\_\_\_\_, School, \_\_\_\_\_, Illinois