CASS SCHOOL DISTRICT NO. 63
8502 Bailey Road
Darien, IL 60561

SCHOOL MEDICATION PERMISSION
for
STUDENT SELF-ADMINISTRATION OF MEDICATION

STUDENT'S NAME____ BIRTH DATE_________________

ADDRESS____ PHONE______________________

SCHOOL____________________________ GRADE________ TEACHER____________________

In case of emergency, please contact:____________________________ ____________________________
(name) (phone number)

FAMILY PHARMACY ____________________________________ ____________________________
(name) (phone number)

*I, ____________________________, *parent *legal guardian *primary caretaker of the student named herein provide my permission for my son/daughter to self administer medication during the school day in accordance with the medication information provided below. I have received and reviewed the District's medication administration policies and guidelines and had the opportunity to have my questions answered by appropriate District staff. Furthermore, I have discussed with my son/daughter the appropriate amount of medication to be taken and the times at which the medication should be taken, and it is my belief that s/he fully understands the importance of taking only the prescribed or recommended amount of medication and the consequences of not following the instructions for administering the medicine. My son/daughter has demonstrated to my satisfaction his/her capability to appropriately administer this medication, and I have no knowledge that s/he misuses or otherwise abuses medications which would contraindicate the District consenting to him/her self administering medications. By requesting the District allow the self administration of medication by my son/daughter I agree to hold the District harmless for any injury that may occur due to the improper use of this medication by my child.*

____ ____________________________
Parent/Legal Guardian/Primary Caretaker Signature Date

TO BE COMPLETED BY THE PHYSICIAN:

(or attach similar written information on the physician's letterhead and signed by the physician)

MEDICATION____

DOSAGE____ TIME________________________

LENGTH OF TIME for which student will need to take medication ____

TYPE OF DISEASE OR ILLNESS____

IS DISSEMINATION OF THIS MEDICATION NECESSARY DURING THE SCHOOL DAY FOR THE CHILD?

____

~over~

POSSIBLE SIDE EFFECTS: ____

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This student has been advised of the proper use of this medication and the risks associated with misuse of the medication. The student is capable of appropriately administering the medication as instructed, and I have no knowledge of or reason to believe the student would misuse or otherwise abuse the medication.

______________________________	______________________________	____________
Physician Signature	Physician's telephone number	Date

IMPORTANT INFORMATION:

1. Medication is to be brought to the school in a pharmaceutical container, clearly marked with the child's name, the name of the medication and pertinent instructions.

2. The parent must report immediately any changes in prescription or dosage. New permission forms must be obtained for each change.

3. Parents will be notified whenever a PRN ("as needed") medication is given to the child.