DUNLAP COMMUNITY UNIT SCHOOL DISTRICT #323

Physician and Parent Permission to Administer Medication

I hereby give permission to personnel in the Dunlap Community Unit District to

administer medication to _____during
(Student's Name)
the school day or during school sponsored activities as described below.

I understand that personnel being requested to administer medication ARE NOT trained medical personnel and that they have little, if any, knowledge of medical procedures.

_____	_____
Attending Physician's Signature	Parent / Guardian's Signature
_____	_____
Address	Address
_____	_____
Physician's Phone Number Date	Work Phone Home Phone Date

Type of Medication_____ Dosage_____

Time to be given_____

Effective Date(s): From _____to_____

Possible Side Affects from this medication: _____

_____

Protocol / Procedures /Actions to be taken in case of a reaction to this medication: ____

_____

_____

Note: 1. Medication must be brought by the parent / guardian to the school office in containers properly labeled by the pharmacy.
2. The label must include the name of the student, the physician, the dosage, and the time to administer the medication.

My signature below absolves the district and its personnel of any and all responsibility related to the administering of the above named medication and/or the results of administering said medication.

_____
Parent / Guardian's Signature Date