Community Consolidated School District 46

Pupil Services Department

CCSD 46 | 103 E Belvidere Road, Hainesville, IL 60030 | 847-543-6225 | FAX 847-543-4132

Mrs. Heather Lorenzo, M.S. Ed.
Director
lorenzo.heather@d46.org

Mrs. Linda Mizwicki, M.S. Ed.
Coordinator
mizwicki.linda@d46.org

MEDICATION ADMINISTRATION PERMISSION FORM

Academic Year ____________

Student Name: ______________________________ Date of Birth: ______________________

Address: ____

Telephone Number: ___________________________ Grade:____________________________

By signing below, I request that the named student receive the medication noted below from Community Consolidated School District #46 school personnel, on my behalf and stead, according to school policy. I agree to deliver the medication timely to the school, in its original labeled container. I will notify the school if the medication is changed or discontinued. I understand it is the student's responsibility to report on time for this medication. I fully release the school, its employees, and board from all liability related to the administration of this medication and from any injury arising from the student's self-administering or self-possession of this medication.

___________________________________ _____________ _________________________

Parent/Guardian Signature Date Relationship

TO BE COMPLETED BY HEALTHCARE PROVIDER

Name of Medication: ____

Form of Medication:

__ Tablet/Capsule __ Liquid __ Inhaler __ Injection

__ Nebulizer __ Other: ____

Schedule and Dosage: ____

__ For academic year

__ For dates between: Start Date: ________________ Stop Date: ________________

__ For episodic/emergency events only

Adverse Reactions to Report to Physician: ____

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TO BE COMPLETED BY HEALTHCARE PROVIDER CONTINUED

Special Storage Requirements: __ None __ Refrigerate __ Other:__________________

Self-Administering: This medication is critical to the student's wellbeing.
This student is both capable and responsible for self-administering this medication.
__ No __ Yes - Supervised __ Yes - Unsupervised

Self-Carry: This medication is critical to the student's wellbeing. This student may carry this medication.
__ No __ Yes

HEALTHCARE PROVIDER SIGNATURE REQUIRED

________________________________ ________________________________ ______________
Healthcare Provider Signature Printed Name Date

____ ________________________________
Address Phone Number