Community Consolidated School District 46
Student Services Department
CCSD 46 | 103 E Belvidere Road, Hainesville, IL 60030 | 847-543-6225 | FAX 847-543-4132

Dr. Heather Lorenzo, Ed.D.
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: _____
_____

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

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FORMULARIO DE AUTORIZACIÓN PARA ADMINISTRAR MEDICAMENTOS

Año escolar _____

Nombre del estudiante: _____ Fecha de nacimiento: _____

Dirección: _____

Teléfono: _____ Grado:_____

Con mi firma, solicito que el estudiante aquí nombrado reciba por parte del personal del Distrito #46, el medicamento indicado en este formulario, en mi nombre y lugar, de acuerdo con la política escolar. Me comprometo en entregar el medicamento en la escuela de manera oportuna, en su envase y con etiqueta original. Notificaré a la escuela si el medicamento cambia o se suspende. Entiendo que es responsabilidad del estudiante presentarse a tiempo para recibir este medicamento. Eximo completamente a la escuela, a sus empleados y a la junta educativa de toda responsabilidad relacionada con la administración de este medicamento y de cualquier lesión que surja de la autoadministración o posesión de este medicamento por parte del estudiante.

_____	_____	_____
Padre de familia/tutor legal	Fecha	Parentesco

TO BE COMPLETED BY HEALTHCARE PROVIDER (Esta sección debe ser completada por el médico)

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

TO BE COMPLETED BY HEALTHCARE PROVIDER Cont.(Esta sección debe ser completada por el médico)

Adverse Reactions to Report to Physician: _____
_____

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