SPEED S.E.J.A. #802
1125 Division Street - Chicago Heights, IL 60411
Phone (708)_____ Fax (708)_____

School Year _____

MEDICATION AUTHORIZATION FORM

Permit for SPEED Personnel to Administer Required Mediations during School Hours

Student Name _____School _____

(TO BE COMPLETED BY LICENSED PRESCRIBER)

Date _____

This student_____ is under my medical care for

_____ and medication is required

during the school day for the purpose of _____

Name of Drug	Dosage	Frequency	Time To Be Given At School/ Education Setting	Duration	Side Effects

Signature of Licensed Prescriber _____

Printed Name of Licensed Prescriber _____

Address _____

_____

(City) (State) (Zip Code)

_____

Telephone Number Fax Number

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I, _____, give permission for my child to receive the above medication(s) as directed by the licensed prescriber. The medication will be sent to school/educational setting in a container appropriately labeled by the pharmacy. I will notify the school in writing if the medication is discontinued. I will also obtain a written order from the licensed prescriber if the medication dosage is changed. I will bring the medication to the school nurse or notify the school nurse if extenuating circumstances exist regarding transport of medication to the educational setting.

Date_____

Parent/GuardianSignature_____

Address_____

_____

City, State and Zip Code

Home phone _____ Cell/Work Phone _____