CHICAGO PUBLIC SCHOOLS

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone	Zip Code

I _____ (Mother, Father, Legal Guardian) of the above named student, give permission to the school nurse to administer medication as requested by my child's physician _____ during school hours.

NAME OF PHYSICIAN

I will bring the medication to school nurse or principal/designee in original container appropriately labeled by the pharmacist or licensed provider.

_____
Signature of Parent / Guardian

_____
Address

_____
City Zip

_____
Home Phone Business Phone

_____
Date

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

Rev 11/04