CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has _____
Name of Disease , condition, or Syndrome

I am requesting that the above named student be allowed to self-administer the following medication **under adult supervision** during school hours:

Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler
Dosage	Time to be given

Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____**Hospital Affiliation**_____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____ **Date** _____

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

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