

**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.**