

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

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

The above named student has _____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler	
Dosage	Route	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 change in medication or dose requires a new request form.**