Southland College Prep Charter High School

3718 W. 213th Place, Matteson, IL. 60443 Office Phone (708) 748-8105

Authorization for Administration of Medication During School Hours

(A separate sheet is required for each medication)

Student Name: ____________________________________ **Date of Birth:** ___________________

To Be Completed by Physician

Diagnosis: ____

Name of Medication: ____

Dose to be Given at School: ____

Time(s) to be Given at School: ____

Desired Effect(s): ____

Possible Side Effects: (circle any effects that should be reported) __________________________

____

Expected Duration of Administration: ____

Date: _____________________ **Physician Signature:** _____________________________________

Physician Name (print or stamp information): ____

Address: ____

Phone Number: ____

Emergency number (if different): ____

To be Completed by Parent of Guardian

I give permission for my child to receive the above referenced medication during school hours as directed by the physician in accordance with the guidelines set forth by Southland College Prep Charter High School. I give permission for the school district to contact the above physician in regard to the above medication. I understand that changes in the dose of the medication must be verified in writing by the physician.

Parent/Guardian Signature:__________________________________ **Date:** __________________

School Hours Phone Contact: _________________________ **Cell Phone:** ____________________

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