

Physician's Request for Unsupervised Self-Administration of Medication Form

This form may be filled out 2 ways before returning to school office:

- 1. Click on the fields, type in information, and print.**
- 2. Print out form, and write information *legibly*.**

Student Name

Date of Birth

To Principal, St. Joseph School, Wilmette, Illinois:

The above named child has _____.

Name of medical condition or illness

I am requesting that the above named student be allowed to take the following medication during school hours or during school-related activities:

Name of medication

Type of medication (tablet, liquid, capsule, inhaler, injectable)

Dosage

Time(s) to be taken or administered

Possible side effects

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision. (Circle One):

Yes

No

For ASTHMA and ALLERGY CONDITIONS ONLY: I also request that this student be allowed to carry the above-described medication on their person during school hours and during school related activities in order to facilitate the self-administration of the medication as needed. (Circle One):

Yes

No

Signature of Physician

Date

Name of Physician

Address, City, State

Emergency telephone number