

## Unsupervised Self-Administration of Medication Request Form

\_\_\_\_\_  
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