To be updated by parent/guardian/physician annually

Physician's Order

Student ______________________________ Grade ___________

________________________ ___________ ______________________________
Medication/ Health Care Treatment Dosage Time(s) to be administered

______________________________ ______________________________
Intended effect of this medication Expected side effects, if any

____
Other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**
   (Please circle) YES NO

2) **For** ASTHMA **and** ALLERGY CONDITIONS ONLY:
   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.

   (Please circle) YES NO

   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.

   (Please circle) YES NO

Administration Instructions:

______________________________ ______________________________
Physician's /Prescriber's Signature Date Signed

______________________________ ______________________________
Physician's/ Prescriber's Name (PRINT) Emergency telephone number

____
Address City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of ____________,
(Please circle one)

20 ___, by ______________________________ on behalf of
Signature of Principal

______________________ School, __________________, Illinois