Naperville 203
Community Unit School District

## PHYSICIAN'S ORDER FOR SCHOOL MEDICATION

Student's Name: _____ Birthdate: _____ Grade: _____

Address: _____ Phone: _____ School: _____

### TO BE COMPLETED BY THE PHYSICIAN

Only medications which are prescribed by a physician and **which are essential for the student to remain in school** shall be given. Please indicate whether this medication **must** be taken during the school day. **Yes** ☐ **No** ☐ **Diagnosis:** _____

Medication: _____ Dosage: _____ Route: _____

Frequency: _____ Scheduled ☐ or PRN ☐

Indication: _____ Side Effects: _____

Other Medication(s) Student is Taking: _____

Duration of Order: Current School Year or other: (specify duration) _____

The **student will self-administer this medication** in the school health office **with supervision**, or the medication may be administered by a district staff member.

**X**_____ _____ _____

PHYSICIAN/LICENSED PRESCRIBER'S SIGNATURE PRINTED NAME DATE

OFFICE PHONE NUMBER: _____ OFFICE FAX NUMBER: _____

## PARENT/GUARDIAN AUTHORIZATION FOR SCHOOL MEDICATION

I hereby request that Naperville School District 203 employees administer or supervise the administration of medication in accordance with the routine described under the Guidelines for the Administration of Medication in Naperville School District 203. **I understand that I will need to pick up unused doses of the medication at the end of the school year. Unused medication will not be sent home with my child and will be destroyed if not picked up by the last day of school.**

I hereby release Naperville Community Unit School District 203 and any of its agents, employees administrators or other parties (hereinafter, the "District") from any liability for any injury or harm which is suffered by (student's name) _____ as a result of our District's agreement to honor this request. I agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

**Please return this form with your child's medication to the school health office.**

Revised 4/15