

Fox River Grove School District 3
403 Orchard Street, Fox River Grove, IL 60021
Telephone (847) 516-5100

Request for the Administration of Medication During School Hours

Prescription Medication: Physician completes Part A. Parent/Guardian completes Part B and returns this form to school.

Non-Prescription Medication Administered for More Than Three Days: Physician completes Part A. Parent/Guardian completes Part B and returns this form to school.

Non-Prescription Medication Administered for Three Days or Fewer: Parent/Guardian completes Part B and returns this form to school.

PART A - PRESCRIPTION MEDICATIONS

Student Name _____
Birth Date _____ Grade Level _____
Medication _____
Dosage _____ Time of Administration _____
Reason for Medication _____
Special Instructions _____

May carry inhaler _____ May carry Epi pen _____

DOCTOR'S SIGNATURE _____

Date _____ Phone _____

PART B - NON-PRESCRIPTION MEDICATIONS

Student Name _____
Birth Date _____ Grade Level _____
Medication _____
Dosage _____ Time of Administration _____
Reason for Medication _____
Special Instructions _____

Parents/Guardians: All medications taken at school must be brought to the nurse's office. The medication is to be in a container that is appropriately labeled (by the doctor or the pharmacy) with the pertinent information described above. In the case of non-prescription medications that are to be administered for a period of three days or fewer, the parent may provide the required labeling.

I hereby request and grant permission for District 3 School Personnel to dispense medication to my child, _____, according to (~physician's name) _____. or non-prescription medication on a limited basis (3 consecutive days or fewer) according to my instructions. I agree to hold harmless and indemnify the school district, its employees and agents; either Jointly or severally, from and against any and all liability, claims, demands, or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the administration of medication.

PARENT SIGNATURE _____ Date _____