Northwestern Community Unit School District #2
Consent to Administer Prescription Medications

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the building principal's office.

Student's Name:_____ Birth Date:_____

Address: _____

Home Phone: _____ Emergency Phone:_____

School: _____ Grade:_____ Teacher:_____

To be completed by the student's physician, physician assistant, or advanced practice RN.

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____Emergency Phone: _____

Medication Name _____

Purpose:_____

Dosage: _____ Frequency: _____

Time to be administered or under what circumstances: _____

_____

Prescription Date: _____ Order Date:_____ Discontinuation Date:_____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school Day ____yes ____no

Expected side effects if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving :_____

_____

_____

Physician's Signature Date