COOK COUNTY SCHOOLS
INDEPENDENT SCHOOL DISTRICT 166

M-3 Prescription Medication
Medical Order and Authorization to Administer Permission Form

Name of Student:	Birthdate:
Grade:	Teacher Contact:

The following medication(s) is necessary for this student to receive during the school day:

Medication	Dose	Route	Medication Form (ie. Tab, pill)	Frequency	Time of day to be given	Reason for medication

***unless indicated otherwise, start date of medication administration shall be the time this form is received and medication has been delivered to the health office, and stop date will be the last date of the school year**

Pharmacy Name:_____ Contact Phone Number:_____ Clinic Name:_____ Clinic Phone Number:_____ Health Care Provider Name:_____ License Number:_____ Health Care Provider Signature:_____ Date:_____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this student's health care provider (HCP). I understand I must provide prescription medications in an original pharmacy container with a current label. Over-the-counter preparations must be provided in the original, labeled container. A controlled prescription medication must be brought to school by a parent/guardian.

2. I give permission for the school registered nurse, a trained health office assistant or delegate to administer the medications prescribed to my child.
3. I will immediately notify the school of any change in the medication or Health Care Provider's (HCP) order, dosage change, frequency, or duration of administration.
4. I give permission for this information to be released to school personnel. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.
5. I understand that I can refuse to share this information with other school staff (contact school nurse).
6. I release all school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

ONLY the following persons (name and relationship to student) have permission to drop off AND pick up medication from school health office:

_____

_____

Parent/Guardian Name_____ Signature:_____

Contact Phone Number _____ Date_____