Wood Dale School District 7
<u>School Medication Permission Form</u>

Student Name____ Birthdate______________________________

Address____ Telephone_____________________________

School_______________________________ Grade_________ Teacher________________________________

In Case of Emergency, Please Contact:

Name____ Telephone________________________________

Relationship____________________________________

I hereby request permission for my child to self-administer the medicine described below. I understand the school accepts no responsibility for the proper administration of the medication.

Parent/Guardian Signature______________________________________Date__________________________

To Be Completed by the Physician:

Name of Medication:	Date:	Dose:	Time:	Side Effects:
___________________________	________	___________	_________	___________________________
___________________________	________	___________	_________	___________________________

Further Instructions: ____

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Is medication necessary to maintain child at school? ______________________________

____________________________	___________________________	___________________	________
Physician's Signature	Physician's Name (please print)	Telephone Number	Date

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Important Information:

1. **Medication is to be brought to school in the original pharmaceutical container, clearly marked with the child's name, the name of the medication, and pertinent instructions.**
2. **The parent or physician must report immediately, in writing, any change in prescription or dose.**