Grade School
Phone #: (217) 742-9551
Fax #: (217) 742-0014

High School
Phone #: (217) 742-3151
Fax #: (217) 742-0311

Winchester Community School District #1

AUTHORIZATION AND PERMISSION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION

Student Name:_____ DOB:_____ Grade: _____

This order is valid for school year 2019-2020

PART I: PHYSICIAN'S STATEMENT

1. Medication: _____
2. Dosage / Amount to be given: _____
3. Route of administration: _____
4. Frequency / Times to be administered: _____
5. Duration (week, month, indefinitely, etc.): _____
6. Anticipated reaction to medication (symptoms, side effects, etc.): _____
8. Diagnosis requiring medication: _____
9. Other Medication student is receiving: _____

_____

_____

Physician's Printed Name / Physician's Signature **Date**

_____

Phone # **Fax #**

PART II: PARENT'S/GUARDIAN'S REQUEST/APPROVAL

I hereby request and give my permission for the qualified school staff to administer to my child the medication as prescribed by the licensed provider on this form. I certify that I have legal authority to consent to the administration of medication at school. I authorize the school nurse to communicate by telephone or by fax with the licensed prescriber regarding the administration of this medication.

Parent's/Guardian's Signature: _____ Date: _____