Westchester Public Schools
District 92½

Request for the Administration of Medicine

Medications cannot be administered at school without a doctor’s written order and a written request from the parent or guardian.

When this request is received by the school, it will remain on file and in effect for the remainder of the school year unless specifically limited by the physician. This form may be returned to the health clerk in the Health Office or faxed to the health clerk at the appropriate school:

   WPS Fax - (708) 562-1547  WIS Fax - (708) 562-0299  WMS Fax - (708) 450-2752

Student’s Name __________________________________________________________
Address __________________________________ Date of Birth ________________________________
________________________________________________ Emergency Phone _________________________
School __________________________________ Grade ________________________________

Part I – Physician’s Statement

1. Name/type of medication _____________________________________________________
2. Dosage/amount to be given ____________________________________________________
3. Route of administration ______________________________________________________
4. Frequency and time of administration __________________________________________
5. Duration (week, month, indefinite, etc.) __________________________________________
6. Diagnosis, intended effect and anticipated reaction to medication ______________________
   __________________________________ Symptoms, side effects, etc. ___________________________
7. Other medication child is receiving _____________________________________________
8. Other requirements ____________________________________________________________

9. Must this medication be administered during the school day in order to allow the student to attend school? _____ Yes     _____ No

____________________________ ______________________________
Physician’s Signature Date Signed

____________________________
Physician’s Address

____________________________
Physician’s Phone Number

Part II – Parent’s Request/Approval

I hereby request and grant permission for School District 92½ school personnel to dispense medication to my daughter/son, according to the above instructions. I further waive any claims against the School District members of the Board of Education, its employees and agents arising out of the administration of said medication and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action of injuries, costs, and expenses, including attorneys’ fees, resulting from or arising out of the administration of medicine.

____________________________ ______________________________
Signed Date

Daytime Phone # ______________________________

March 2016