# Physician's Request for Self-Administration of Medication

As required by Illinois School Code (22-30)

Student's Name ____________________________________________________________

Patient's/Guardian's Name ____________________________________________________________

I am requesting that the above named student take the following medication(s) during school hours.
Name of
Medication(s)________________________________________________________________________

________________________________________________________________________

Purpose of
Medication(s)________________________________________________________________________

________________________________________________________________________

Dosages(s)________________________________________________________________________

________________________________________________________________________

Medication Administration/Time and/or Circumstances:__________________________________

________________________________________________________________________

Possible side effects ____________________________________________________________

________________________________________________________________________

I certify that ________________________________________ has been instructed in the use and self-
(Name of Student)

administration of ________________________________________________________________
(Name of Medication(s))

He/She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

__________________________________________________ __________________________
Print Name of Physician Phone number of physician

__________________________________________________ __________________________
Physician's Signature Date