Salt Fork CUSD # 512

7087 North 600 East Rd
Sidell, IL 61876
North Campus High School: 217-427-5331; Fax 217-427-2468
North Campus Elementary: 217-427-5421; Fax 217-427-9866
South Campus Elementary/Jr. High: 217-288-9394; Fax 217-288-9306
Unit Office: 217-288-9306

SCHOOL MEDICATION AUTHORIZATION FORM

Student's Name: _____Birth Date:_____

Address: _____City/State: _____Zip: _____

Home Phone: _____Emergency Phone: _____

School: _____Grade: _____

Next section to be completed by the student's physician, physician assistant, or advanced practice RN. (Note: For asthma inhalers only, use the Asthma Inhalers" section below.)

Office Address: _____City/State: _____Zip: _____

Office Phone: _____Emergency Phone: _____

Medication Name: _____Purpose: _____

Dosage: _____Frequency: _____

Time medication is to be administered or under what circumstances:

Prescription Date: _____Order Date: _____Discontinuation Date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day: _____Yes or _____No

Expected side effects, if any: _____

Time Interval for re-evaluation: _____

Other medications student is receiving: _____

Asthma Inhalers:

Parent/Guardian please attach prescription label here:

Authorization to administer the following medications at school:

_____***Acetaminophen (Tylenol)*** _____***Benadryl***

_____***Ibuprofen (Advil)*** _____***Tums***

_____ _____*Date:*_____

Physician's Printed Name ***Physician's Signature***