Lake Forest Pediatric Associates
Lake Forest • Lindenhurst • Vernon Hills

SCHOOL MEDICATION AUTHORIZATION FORM
Prescription and Non-Prescription

To be completed by Parent or Guardian:

I, ___________________________________, parent/guardian of ________________________, hereby authorize ______________________________ school and its employees and agents to administer to my child prescribed medication in the manner described below. I also authorize my child to self-administer the prescribed medication in the manner described below while under the supervision of the employee or agents of the school.

_____________________________ _____________________________
Parent or Guardian Signature Date

Student's Name: ___________________________________ Date of Birth: _______________

Address: ___________________________________ Phone: ______________________

Medication: ____

Dosage: __________________________________ Time Given: ________________________

Purpose of Medication: ____

Possible Side Effects: ____

Today's Date: _____________________________ Physician Signature: _________________