

Proviso West High School 4701 Harrison St, Hillside, IL 60162 Office: 708-202-6205 Fax: 708-202-6974

MEDICATION PERMIT

		/ /	
Name of Student	ID#	Birthdate	
The above-named pupil has			
	(Name of Dise	ease or Syndrome)	
I am requesting that the above-name	d student take the following m	edication during school hours.	
Name of Medication	Type of Medication:	Tablet, Liquid, or Capsule (Please Circle)	
Dosage	Time(s) to	Time(s) to be given	
	Possible Side Affects		
	has been	en instructed in the use and	
(Name of Stu	dent)		
self-administration of			
	(Name of Mee	dication)	
I hereby authorize my child to self-ad agents of the School District, lawfull He/she understands the need for the unusual side effects. He/she is capab	y prescribed medication in ma medication, and necessity to re	nner described above. eport to school personnel any	
I may be reached at the following ph	one number in the event of a r	eaction or an emergency:	
	/ /	()	
Signature of Parent	Date	Daytime Phone	
		()	
Name of Emergency Contact	-	Daytime Phone	