Proviso Township High Schools District 209
Medication Self-Administration Permit

_____ _____ ____/____/____
Name of Student ID# Birthdate

The above-named pupil has _____
(Name of Disease or Syndrome)
I am requesting that the above-named student take the following medication during school hours.

_____ Type of Medication: Tablet, Liquid, or Capsule
Name of Medication (Please Circle)

_____ _____
Dosage Time(s) to be given

_____
Possible Side Affects

I certify that _____ has been instructed in the use and
(Name of Student)

self-administration of _____
(Name of Medication)

I hereby authorize my child to self-administer, while under the supervision of the employees and agents of the School District, lawfully prescribed medication in manner described above.

He/she understands the need for the medication, and 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 number in the event of a reaction or an emergency:

_____ ____/____/____ (_____)_____-_____
Signature of Parent Date Daytime Phone

_____ (_____)_____-_____
Name of Emergency Contact Daytime Phone