



Lake Forest Pediatric Associates

Lake Bluff • Lindenhurst • Vernon Hills

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lakeforestpediatrics.com

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: _____