Lake Forest
Pediatric Associates
Lake Bluff • Lindenhurst • Vernon Hills

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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: _____

(school medication authorization 9/13/2023)