



Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

STUDENT SERVICES DEPARTMENT

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MEDICATION ADMINISTRATION FORM

Effective School Year: 20 to 20 Today's Date:

Student Name: D.O.B.: Grade

Name of Medication:

Frequency/time/route of administration:

Time interval of re-evaluation:

Diagnosis Requiring Medication:

Side Effects:

Rescue Inhaler and/or Epipen - we recommend "back up" medication to be stored in the Health Office
1. Student may carry medication on his/her person
2. Student may self-administer medication

Parental authorization:
I acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, medicine will be administered by district health personnel only in exceptional circumstances where the prescribed medication interval requires that it be administered during school hours and when the parent requests and a physician certifies that the timing of such medication requires administration in school.

Parent's signature

Doctor's signature

Address

Address

Home phone/cell phone

Phone number / emergency number

Date

Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.