SYCAMORE COMMUNITY SCHOOLS

UNIT DISTRICT NUMBER 427

ADMINISTRATIVE OFFICES • 245 WEST EXCHANGE STREET • SYCAMORE, ILLINOIS 60178

Wayne E. Riesen, Ed.D.,
Superintendent

BUS: 815/899-8103
FAX: 815/899-8110

Kathy Countryman
Assistant Superintendent

BUS: 815/899-8104
FAX: 815/899-8110

Luke V. Glowiak, Assistant
Superintendent for Business

BUS: 815/899-8100
FAX: 815/899-8119

SCHOOL MEDICATION PERMISSION

Student's Name ________________________________ Birthdate ____________________

Address ______________________________________ Telephone No. ________________

School _________________ Grade _______________ Teacher _____________________

I hereby grant permission for the medication described below to be administered to my child at school. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practice.

___________________________________ ______________________________________
Parent Signature Date

CONSENT FOR RELEASE OF MEDICATION INFORMATION

I hereby grant permission for the school nurse to exchange information with the treating physician regarding medication administered to my child at school.

___________________________________ ______________________________________
Parent Signature Date

PRESCRIBED MEDICATION INFORMATION

(To be completed by the physician)

Diagnosis ____

Name of Medication ____

Dose ____Time____________________

Is this medication necessary in order to maintain the child at school? ________________

Possible side effects ____

__________________________________ ____________ _________________________
Physician Signature Date Telephone Number