

**SOUTHWEST COOK COUNTY COOPERATIVE  
ASSOCIATION FOR SPECIAL EDUCATION**

**MEDICATION(S) – PARENT/PHYSICIAN AUTHORIZATION**

Student Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Program/Location: \_\_\_\_\_

MEDICATION	DOSAGE	ROUTE OF ADMINISTRATION	ROUTE OF ADMINISTRATION
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Condition and purpose for which medication prescribed: \_\_\_\_\_  
\_\_\_\_\_

Necessity for medication during school hours: \_\_\_\_\_  
\_\_\_\_\_

Comments (Include special instructions, possible side effect, etc.): \_\_\_\_\_  
\_\_\_\_\_

\*When "PRN" is noted, please list specific conditions, which would warrant administration:  
\_\_\_\_\_

Above student may safely self-administer above-listed medications.  Yes  No

School personnel other than a school nurse may safely administer above-listed medication for above student  
 Yes  No

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
(Where a physician can be reached in an emergency)

.....  
**PARENT AUTHORIZATION:**

Regarding the above listed medication(s), I hereby authorize the:

- Administration of medication to my child by individual as specified in SWCASE.  
Medication Administration Policy.  Yes  No
- Self-administration of medication by my child by individuals as specified in SWCASE.  
Medication Administration Policy.  Yes  No

I have received a copy of said policy and am familiar with its contents. I further authorize the release and exchange of information between SWCASE and the following physician(s) or agency(ies) regarding above listed medication(s):  
\_\_\_\_\_

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_