UIC COLLEGE PREP LSV CAMPUS

1231 S. Damen Ave.
Chicago, IL 60608

p: 312.768.4858
f: 773.496.7149

PARENT
REQUEST FOR SELF-ADMINISTRATION

Name of Student ______________________ Birth Date ____________ ID Number ____________

Address ______________________ Telephone Number (____)__________ Zip Code ____________

I (Mother, Father, and Legal Guardian) of the above named student give my permission to the school office to monitor my child's self-administration of the following medication:

____

____

Signature of Parent/Guardian ______________________ Date ____________

Work Phone Number ______________________ Home Phone Number ______________________

I acknowledge that Noble Street Charter School- UIC College Prep and its employees and agents are to incur no liability, except to willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. The student understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Parent Signature ______________________ Date ____________

Student Signature ______________________ Date ____________

uiccollegeprep.org

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PHYSICIAN
REQUEST FOR SELF- ADMINISTRATION OF MEDICATION

____________________ ________________ ______________

Name of Student Birth Date ID Number

____________________ (____)__________ ______________

Address Telephone Number Zip Code

The above name student has ______________________________

Name of Disease or Syndrome

I am requesting that the above named student take the following medication during school hours:

____________________ ________________________

Name of Medication Type of Medication (Tablet, Liquid, Capsule or Inhaler)

____________________ ________________________

Dosage Time(s) to be taken

____________________ ________________________

Possible Side Effects

I certify that the student named above has been instructed in the use and self-administration of above medication. The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

____________________ ________________________

Print Name of Physician Signature of Physician

____________________ (____)____________________

Address Phone Number

____

Date

I acknowledge that Noble Street Charter School- UIC College Prep and its employees and agents are to incur no liability, except to willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. The student understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

____________________ ________________

Parent Signature Date

____________________ ________________

Student Signature Date