Dupo School District 196
600 Louisa Ave. Dupo, IL. 62239
Jr./Sr. High School Phone 618-286-3812 x4135 Fax 618-286-5535
Bluffview Elementary Phone 618-286-3311 x3219 Fax 618-286-4092

Medication Consent Form as required by the State of Illinois

Name of Student _____ Birthdate _____

Address _____ Telephone _____

School Attending _____ Grade _____

FOR THE PHYSICIAN

Name of medication to be given: _____

Disease/Illness medication is to be given for _____

Dosage to be given _____

Time to be given _____

Possible length of time to be given _____

Possible side effects of this medicine _____

If asthma medication is required, please indicate if it is medically necessary for the student to carry the asthma medication with him/her at all times during school hours: ☐ Yes ☐ No

Physician's Signature _____ Date _____

Address _____ Telephone _____

FOR THE PARENT/GUARDIAN

I give consent for my child _____
Name of Child

to receive the above described medication(s) while at school.

My child is currently receiving the following medication(s) _____

Date medication(s) started _____

This form must be completed each time there is a change in any medication. Medication must be brought to school in a container appropriately labeled by either the pharmacist or physician. NO MEDICATION WILL BE GIVEN UNTIL THIS COMPLETED FORM IS RECEIVED. If the school nurse is not in, other certified personnel will administer medication.

- Additional forms will need to be completed if this medication is for asthma, which needs to be self-administered during the school day.

Parent/Guardian Signature _____ Date _____