

**Newark Community Consolidated School
District # 66**

*Dr. Diane Cepela, Superintendent / Principal
Ms. Demetra Turman, Principal*

**Physician Request for Self-Administration of Medication
(Inhaler and Epinephrine Auto-Injector Only)**

Student: _____ Birthdate: _____

Address: _____ Phone Number: _____

TO:
Principal: _____

School: _____

The above named student has _____
(Name of disease or allergy)

I am requesting that he/she take the following medication during school hours:

Name of medication	Dosage	Time(s) of administration
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Possible side effects could include: _____

I certify that _____ has been instructed in the use and administration of this medication. (Name of student)

He/she 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.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency:

Physician printed name: _____ Physician phone number: _____

Physician signature: _____ Date: _____

❖ I authorize my child to possess and self-administer **an epinephrine auto-injector/inhaler** (circle appropriate selection) as necessary during school at Newark Grade School District 66.

Parent name and signature _____

Newark Grade School
503 Chicago Road
Newark, Illinois 60541
Phone 815-695-5143
Fax 815-695-5776

Millbrook Junior High School
8411 Fox River Drive, PO Box 214
Millbrook, Illinois 60536
Phone 630-553-5435
Fax 630-553-1027