NEWHOPE ACADEMY WEST CAMPUS
3250 N. Arlington Heights Road, 200 Wing
Arlington Heights, IL 60004
p 847.588.0463 (press 2)
f 847.588.0374

NEWHOPE ACADEMY EAST CAMPUS
3250 N. Arlington Heights Road, Suite 150
Arlington Heights, IL 60004
p 847.588.0463 (press 1)
f 224.735.3075

AUTHORIZATION TO ADMINISTER MEDICATION

*****This form must be signed by physician AND parent/guardian.*****

Student Name: _____ **Date of Birth:** _____
Last *First* *Nickname* **Date of Admission:** _____

TO BE COMPLETED BY THE PHYSICIAN

PRESCRIPTION MEDICATION TO BE ADMINISTERED AT SCHOOL

Medication Name	Dosage	Time & Frequency

Intended Effect of Medication:

Specific Instructions:

Common Side Effects:

Medication is for:

OVER-THE-COUNTER MEDICATION (as needed)

☐ Ibuprofen (i.e., Advil, Motrin)	Dosage: _____ 200 mg every _____ hours
☐ Acetaminophen (i.e., Tylenol)	Dosage: _____ 500 mg every _____ hours
☐ Calcium Carbonate (i.e., Tums)	Dosage: _____ 1,000 mg every _____ hours
☐ Antihistamine (i.e., Benadryl)	Dosage: _____ 25 mg every _____ hours

PHYSICIAN AUTHORIZATION

Physician Name: (please print)			
Address:			
Phone Number:			
Physician Signature:			
Start Date:	____/____/____	**Date to Discontinue:** (1 year maximum)	____/____/____

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Date

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Parent/Legal Guardian Signature

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Parent/Legal Guardian (please print)

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Daytime Phone Number

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Parent/Legal Guardian (please print)

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3250 N. Arlington Heights Road, 200 Wing
Arlington Heights, IL 60004
p 847.588.0463 (press 2)
f 847.588.0374

NEWHOPE ACADEMY EAST CAMPUS
3250 N. Arlington Heights Road, Suite 150
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p 847.588.0463 (press 1)
f 224.735.3075

AUTHORIZATION TO ADMINISTER MEDICATION

*****This form must be signed by physician AND parent/guardian.*****

Student Name: _____ **Date of Birth:** _____
Last *First* *Nickname* **Date of Admission:** _____

TO BE COMPLETED BY THE PHYSICIAN

PRESCRIPTION MEDICATION TO BE ADMINISTERED AT SCHOOL

Medication Name	Dosage	Time & Frequency

Intended Effect of Medication:

Specific Instructions:

Common Side Effects:

Medication is for:

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☐ Ibuprofen (i.e., Advil, Motrin)	Dosage: _____ 200 mg every _____ hours
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PHYSICIAN AUTHORIZATION

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Physician Signature:			
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