



# MINOOKA COMMUNITY HIGH SCHOOL DISTRICT # 111

## PRESCRIPTION MEDICATION FORM

2019-2020 School Year

### TO BE COMPLETED BY PARENT:

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent(s) Name(s) \_\_\_\_\_

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

It is required that the medication be brought to school in its original container or in an appropriately labeled container with the child's name clearly affixed to it. Parent(s)/Guardian(s) need to bring the medication to the nurse's office. **This form will become part of your child's health record.**

The undersigned releases and holds harmless Minooka Community High School District 111 and its employees from all claims that may arise as a result of action or inaction resulting the request herein made. It is understood that the parent or guardian accepts full responsibility for the giving of medication. Medication properly labeled shall be placed in the hands of the School. Label must include: dosage, frequency, manner of application, and Doctor's name.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

.....  
**TO BE COMPLETED BY PHYSICIAN:**

Name of Medication \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Date of Prescription \_\_\_\_\_ Termination of Self-administration \_\_\_\_\_

Type of Illness \_\_\_\_\_ Why is medication needed? \_\_\_\_\_

Is this Medication necessary to maintain this child in school? Yes \_\_\_\_\_ No \_\_\_\_\_

Is this child receiving additional medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list medication(s) \_\_\_\_\_

Side effects or special instructions \_\_\_\_\_

Physician Name \_\_\_\_\_ Office Number \_\_\_\_\_

Address \_\_\_\_\_  
*(Street) (City) (State) (Zip)*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

**ADMINISTRATION USE ONLY**

Nurse Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_