MINOOKA COMMUNITY HIGH SCHOOL DISTRICT #111

PRESCRIPTION MEDICATION FORM

2016-2017 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***

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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 _____