<u>GARDNER ELEMENTARY SCHOOL</u>

#1 Ed Gardner Place Waterloo, IL 62298
Phone: 618-939-3060 Fax: 618-939-3065

❖❖ MEDICINE DISPENSATION FORM ❖❖

All medications, including non-prescription drugs, i.e. Tylenol, Motrin, Benadryl, etc. will not be administered during school hours unless your child's physician has prescribed it and the following form has been completed.

Parents are responsible for the delivery of medication to the school. Medication should <u>not</u> be sent with the student. Medication must be brought in the original bottle with the student's name attached. Medication should be given to the school nurse or other appropriate school personnel.

It is the parent's responsibility to ensure that the licensed prescriber's order, written request and medication are brought to the school. At the end of the school year, or the end of the treatment regime, the student's parent(s) or guardian will be responsible for removing from the school any unused medication. If the parent does not pick up the medication within 2 weeks of the last day of attendance, it will be disposed of.

If you have any questions regarding this policy, please consult your building principal or nurse.

❖❖

❖ TO BE COMPLETED BY PARENT/GUARDIAN ❖

I request that ____________________________ (Student's Name) ________ (Grade) ____________________ (Date of Birth) be given the following medication during school hours as prescribed by his/her physician. I also authorize, as needed, the sharing of information related to my child's health between the school nurse and the health care provider listed below. I understand that it may be necessary for the administration of medication to students to be performed by an individual other than a school nurse, and specifically consent to such practice.

____________________________________ (Parent's Signature)

____________________________ (Phone Number)

❖❖

❖ TO BE COMPLETED BY PHYSICIAN ❖

Name of Drug________________________________Dosage and Route____________________________

Frequency and Time to be Given____

Diagnosis______________________________Possible Side Effects______________________________

____

Intended Effect of Medication____

Other Medications Child is Receiving____

Time Interval: ______________________________ (Date Treatment to Begin) until______________________________ (Date Treatment to End)

____________________________ (Physician's Signature) ___________ (Date) ______________________________ (Physician's Phone/ Emergency #)

____________________________ (Print Name of Physician) ___________ (Date) ______________________________ (Address of Physician)