WATERLOO HIGH SCHOOL

505 E Bulldog Blvd.
Waterloo, IL 62298
Phone: 618/939-3455
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Website: wcusd5.net

Principal: Lori Costello **Assistant Principal: Alan Guehne** **Assistant Principal: Christy Osterhage**
Athletic Director: Mitch North **School Nurse: Kay Haudrich**

Medicine Dispensation Form

All medications; including non-prescription drugs for example, Tylenol, Motrin, Benadryl, etc. will NOT be administered during school hours unless your child's physician has prescribed it and the form below has been completed.

All medication must be dropped off and picked up by a parent. Medication must be brought in the original bottle with the student's name attached. Medication MUST be given to the school nurse.

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 two 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.

I request that _____ _____ _____
(Student 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:_____until_____
(Date Treatment should begin) (Date Treatment should end)

_____ _____
(Physicians Signature and Date) (Physicians Phone and Emergency Number)

_____ _____
(Print name of Physician and date) (Address of Physician)

Our mission is to prepare students to become responsible members of society by providing education, resources and services that encourage accountability, individual growth and lifelong learning.