Rogers Elementary School

200 N Rogers   Waterloo, IL 62298
Phone: 618-939-3454   Fax: 618-939-7980

❖❖ 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 not 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.

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❖ TO BE COMPLETED BY PARENT/GUARDIAN ❖

I request that ____________________________________ ________ _____________________ be given the
(Student's Name) (Grade) (Date of Birth)

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)

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❖ TO BE COMPLETED BY PHYSICIAN ❖

Name of Drug_______________________________________Dosage and Route___________________________________

Frequency and Time to be Given____

Diagnosis_______________________________________Possible Side Effects_______________________________________

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Intended Effect of Medication____

Other Medications Child is Receiving____

Time Interval: ____until____
(Date Treatment to Begin) (Date Treatment to End)

__________________________________ ____________ ____
(Physician's Signature) (Date) (Physician's Phone/ Emergency #)

__________________________________ ____________ ____
(Print Name of Physician) (Date) (Address of Physician)