GALATIA GRADE SCHOOL

200 N Hickory
Galatia, IL 62935
618-297-4570
618-297-4542 Fax

Physician's Order Form for Medications

In accordance with Galatia Unit #1 School district and Illinois State Board of Education guidelines, children's medication should be administered at home. Only those medication, whether prescription or over-the-counter, that are absolutely needed during school hours shall be administered at school and only if the following conditions are met:

1. The office must have written instructions signed by BOTH the parent/guardian and the prescribing physician.
2. The medicine to be given must be brought to school by the parent /guardian in a container appropriately labeled by the physician or pharmacy. If the physician changes the dose or direction the office must have a new medication form.
3. The parent/guardian is responsible for keeping track of when additional medication is needed.
4. 4. This medication sheet will be valid until the end of the school year. A new medication form must be filled
5. ___Advil/ out at the beginning of each school year.

Childs Name____Teacher____________________________

Name of medication:___________________________________Diagnosis___________________________

Time to be administered:__________________________________Dosage_________________________

Termination Date:____________________ Side effects____

Please check next to all over the counter medications that may be administered to the child.(Doctors Signature is mandatory for OTC Meds to be administered)

___Tylenol/Acetaminophen ___Advil/Ibuprofen ___chewable antacids (Tums)

___cough drops ___eye drops ___anti-itch cream

___hydrocortisone cream ___first aid wash ___bee sting swab

___Oral anesthetic (orajel) ___triple antibiotic ointment ___Benadryl (antihistamine)

I hereby give permission for my child to take the above medication during the school day if needed. I understand that the school nurse or designated staff who administers these meds to my child in accordance with these written instructions, shall not be held liable for damages as result of adverse reaction due to administering the medication.

Parent/Guardian____Date_____________

Physician Name____ Phone Number________________

Physician Signature____Date_____________