Elwood Community Consolidated School District #203

MEDICATION FORM

Student: _____ Birthday: _____

Address: _____ Phone: _____

Grade: _____ Teacher: _____

EMERGENCY NUMBERS:

Parent/guardian: _____ Emergency Contact: _____

Please Note:

Medications should be limited to those required during school hours which are necessary to maintain the student's health in school.

All medications given in school, including non-prescription medications, shall be prescribed by a licensed prescriber.

Illinois Department of Human Services and Illinois State Board of Education

The undersigned release and hold harmless Elwood School and its employees from all claims that may arise as a result of action or inaction resulting from the request herein made. I confirm that I am primarily responsible for administering medications to my child. However, in the event that I am unable to do so or in the event of medical emergency, I hereby authorize Elwood School District, and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child or allow self - administration, lawfully prescribed medications in the manner described below. The medication is to be in the original labeled container as dispensed or the manufacturer's labeled container. Label must include: dosage, frequency, directions for use, and date.

I hereby grant permission for the above named child to self-administer the medication described below. YES NO (circle one)

Parent/guardian signature: _____Date:_____

To be completed by physician:

Medication:	
Dosage:	Time(s) of Administration:
Instructions for Administration:	
Date of Prescription:	Discontinuation/Follow up Date:
Diagnosis Requiring Medication:	
Intended effect of Medication:	
Is this Medication necessary to maintain this child in school? YES NO (circle one)	
Possible Side Effects:	
Is this child receiving other medication? If Yes, please list:	
Physician's Name (print or office stamp) Phone:	
Physician's Signature:	Date:

For School Personnel:

Received: