School Year _____

METAMORA CCSD #1

Instructions for Medications Administered at School

The Illinois Department of Public Health requires a statement signed by you and your child's physician for any medication to be dispensed at school. This includes <u>all</u> over the counter medications such as Ibuprofen, Tylenol, Pepto-Bismol, and allergy medicine. Please complete the medication authorization form - see below on the second page. A signed note from the physician will be accepted in the event that your child needs medication and there is no authorization on file.

Medication authorizations are valid for 13 months (same as physicals). If the prescription dosage changes, it is necessary to have a new form filled out. Please complete a separate form for each child. Most physicians will assist with this at no cost to their patients, and the school nurse can assist by faxing the form to the physician's office if needed.

Please bring medication in the properly labeled, original prescription bottle so no errors are made when dispensing. If your child has permission to take over-the-counter medications, it is necessary for the parent/guardian to bring in the medication in original packaging. Please clearly label over- the-counter medications with the student's name.

Do not send medications to school with students. A real tragedy could occur if medication were dropped or lost and another student picked it up and ingested it. Although it may be inconvenient, it is for student protection and safety.

School Year _____

Metamora CCSD #1

Fax: 309-367-2364

MEDICATION AUTHORIZATION

Prescription and Non-Prescription

Please complete the following in order for any medication to be administered to your child at school. This form must be dated, signed by a parent/guardian, and signed by a physician. If your child's medication changes, you are responsible for notifying the school as soon as possible. This form is valid for up to 13 months.

PHYSICIAN'S REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL

Student's Name_____Date of Birth_____

Address_____

Parent/Guardian_____ School: Metamora Grade School

Specific Diagnosis_____

Name of Medication _____

Dosage_____ Time to be given _____

Specific Directions_____

Possible Side Effects_____

_____ _____

Physician Name - Printed Date

_____ _____

Physician Signature Parent Signature

_____

Physician Office Address and Phone