

**Minooka Community High School
STUDENT MEDICATION FORM**

Student's Name: _____ Birthday _____

Address _____ Phone # _____

Parent/Guardian _____
n _____

Please Note:

It is required that the medication be brought to school in its original container or in an appropriately labeled container with the child's name clearly affixed to it. Parents need to bring the medication to the nurse's office.

This form will become a part of your child's health record.

*The undersigned releases and holds harmless **Minooka Community High School** and its employees from all claims that may arise as a result of action or inaction resulting the request herein made. It is understood that the parent or guardian accepts full responsibility for the giving of medication. Medication, properly labeled, shall be placed in the hands of the School. Label must include: dosage, frequency, manner of application, and Doctor's name.*

I hereby grant permission for the above named child to self-administer the medication described below.

Parent/Guardian Signature

Date

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TO BE COMPLETED BY PHYSICIAN:

Name of Medication: _____

Dosage: _____ Time(s) of Administration: _____

Instructions for Administration: _____

Date of Prescription: _____ Termination for Self-administration: _____

Type of Disease or Illness: _____

Purpose of Medication: _____

Is this Medication necessary to maintain this child in school? _____

Possible Side Effects: _____

Is this child receiving other medication? If Yes, Please list: _____

Physician's Name _____ Date: _____

Physician's Signature: _____ Phone: _____

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To be completed by School personnel:
The above medication was received and accepted for self-administering on _____ by _____
Date Signature