MEDICATIONS

Pope Co. Elementary/Jr. High
125 St. Hwy 146 W.
Golconda, IL 62938

In accordance with Pope County Unit # 1 Policy and Illinois State Board of Education guidelines, children's medication should be administered at home. Only those medications, whether prescription or non-prescription, that are absolutely needed during school hours shall be administered at school and only if the following condition are met:

1. We must have written instructions signed by **BOTH** the **parent or guardian** and the prescribing physician. The parent must complete and sign below. The physician may sign below, submit another form or fax instructions to your child's school.

2. The medication to be given must be brought to school by a parent/guardian in a container appropriately labeled by the pharmacy or physician.

3. The parent/guardian must assume the responsibility for keeping track of when additional medication will be needed.

4. This medication sheet will be valid until the end of the school year. A new medication form MUST be signed at the beginning of year school year.

Print Student's Name: _____

Name of Medication: _____ Dose: _____

Purpose of Medication: _____

Time to be Administered: _____

Termination Date: _____

Side Effects: _____

*Asthma – Student is able to self administer inhaler:
(Must be signed by M.D., P.A., or N.P. for child to administer at school)

_____ _____
Physician's Signature **Date**

I hereby request that my child be administered the above listed medications by school personnel and I waive any claims I might have against the School District, it's employees and agents arising out of the administration of said medication.

I also give permission for medical release to school records custodian/staff involved in obtaining and/or releasing information on the above student in regards to behavioral progression and/or medications issues when deemed necessary.

_____ _____
Parent/Guardian Signature **Date**

The School District retains the discretion to reject requests for the administration of medication.

HEALTH AND MEDICAL HISTORY
Pope County Elementary/Jr. High School

GENERAL INFORMATION		
Child's Name	Male · Female ·	Grade entered this school year

Birthdate	Address	Home Telephone
Siblings at current school? Please list.	Family Physician	School Last Attended (City & State)
Father's/Guardian's Name / Phone Number	Mother's/Guardian's name / Phone Number	
Emergency Contact (other than parent)	Emergency Contact Phone Number	Relationship to child

Does child have any allergies? YES NO If yes, please list below.

Medication Allergies	
Food Allergies	
Environmental Allergies	

(Note: Any modifications to the child's diet that are to be provided by the school must be detailed on the Food Modification Form and signed by a physician. Obtain this form from the School Nurse or Secretary)

Is child taking any medication at home? (Prescription or OTC on a routine basis and/or medication taken as needed)
YES NO If yes, please list below. If more space is needed please use back side of this paper.

Medication	Dosage	How often	Med to be taken @ school?

(Note: For meds to be given at school, the Medication Authorization Form must be completed and signed by a physician and by a parent prior to that med being given at school. Obtain this form from the School Nurse or Secretary)

DISEASE HISTORY(Indicate if your child has had any of the following:

Disease	Yes	Year		Disease	Yes	Year
Chicken Pox				Diabetes		
Asthma				Heart		

High Blood Pressure				G.I.		
Seizures				Other:		

Please list any surgeries or major injuries:

Does child wear glasses, hearing aids, etc?

Please add any other information/updates about your child's health that the school nurse should know:

I approve all of the above information to be shared with appropriate personnel for health and educational purposes.

Parent/Guardian signature_____ Date_____