Waterloo Junior High School

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Dr. Nick Schwartz
Principal
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Mrs. Jessica Washausen
Dean of Students
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MEDICAL DISPENSATION FORM

All medications, **including non-prescription drugs**, ie. Tylenol, Motrin, Benadryl, Tums, etc. will not be administered during school hours unless your child's physician has prescribed it and the following form has been completed.

Parents are responsible for the delivery of medication to the school. Medication should <u>NOT</u> be sent with the student. Medication must be brought in the original package, or box with the students name attached. The medication must be in an unopened box. Medication should be given to the school nurse or other appropriate school personnel.

It is the parent's responsibility to ensure that the licensed prescriber's order, written request and medicaiton are brought to the school. At the end of the school year or the end of the treatment regime, the student's parent or guardian will be responsible for removing any unused medication from the school. If the parent or guardian does not pick up the medicaiton within 2 weeks of the last day of attendance, it will be disposed of.

If you have any questions regarding this policy, please counsult the principal or nurse

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I request that ____ be given the
(Student's Name) / (Grade) / (Date of Birth)
following medication during school hours as prescribed by his/her physician. I also authorize, as needed, the sharing of information related to my child's health between the school nurse and the health care provider listed below. I understand that it may be necessary for the administration of medication to students to be performed by an individual other than a school nurse, and specifically consent to such practice.

________________________________ ________________________
(Parent's Signature) (Phone Number)

TO BE COMPLETED BY PHYSICIAN

Name of Drug________________________ Dosage and Route____________________

Frequency and Time to be Given____

Diagnosis________________________ Possible Side Effects____________________

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Intended Effect of Medication____

Other Medications Child is Receiving_____________________________________

Time Interval: ________________________ until ________________________
(Date Treatment to Begin) (Date Treatment to End)

________________________________ ________________________
(Physician's Signature) / Date (Physician's Phone/Emergency#)

________________________________ ________________________
Print Name of Physician / Date Address of Physician