

**MT. ZION COMMUNITY SCHOOLS
MT. ZION, ILLINOIS 62549
MEDICATION FORM**

Mt. Zion School District Fax Numbers

or use phone lines in the front of the Handbook/Calendar

District Central Office..... (217) 864-2200	Mt. Zion Intermediate School (217) 864-5175
Mt. Zion Grade School..... (217) 864-6131	Mt. Zion Jr. High School..... (217) 864-6829
McGaughey Elementary School..... (217) 864-4126	Mt. Zion High School..... (217) 864-5815

TO THE PHYSICIAN:

When it is necessary for a student to self-administer or have the school nurse administer medication during the school day, the following directions to the school personnel/nurse from the physician are required.

_____ should take _____ of
(Name of Student) (Dosage)
_____ at _____ for the _____
(Name of Medication)(Time of Day) (Period of Time)

The diagnosis is: _____

The desired effect is: _____

The side effects are: _____

(Physician's Signature) (Office Phone Number) (Date)

TO THE PARENTS/GUARDIANS:

I hereby give my permission for my child to take _____ as prescribed
above by the physician. (Name of Medication)

(Parent/Guardian Signature) (Date)

Parents/Guardians:

In order for your student to take medication at school, the following criteria must be met:

- A) No more than one-week supply of medication sent to school at one time.
- B) Labeled bottle from the pharmacy for prescription meds or the original container for over the counter meds.
- C) Name of child on bottle.
- D) Name of medication.
- E) Dosage to be given.
- F) Time of administration.
- G) Physician's name.
- H) Date of prescription.
- I) Only one medication per form

*The Mt. Zion School District, along with it's employees and agents, assume no liability (except for willful and wanton misconduct) as a result of any injury arising from the pupil's self-administration of asthma medication.

*Absolutely no antibiotics will be given at school if ordered three times a day or less.

*Information may be shared with appropriate personnel for health and educational purposes.