# Marion Community Unit School District # 2

1700 West Cherry
Marion, IL 62959
618-993-2321

Student Name:_____ Daily Medication your child takes (please list): _____ **None**

| Drug | Dosage | How Often |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

**Parent/Guardian Notification** (please check one):

1. I wish to be called if my child is given an approved medication: ___ Yes ____ No
2. I wish to be called only if the Healthcare provider determines that my child needs to be taken out of school or needs further medical treatment/evaluation: ___ Yes ____ No

Medication listed below will be provided, but not administered, unless there is a parent/guardian's signature at the bottom of this form. **Please indicate which medications can be administered without contacting the guardian with each administration:**

____ Tylenol ____ Ibuprofen ____ TUMS (antacids) ____ Cough drops

____ Anti-histamine (Benadryl, Claritin, etc) ____ Benadryl ointment (topical)

____ Cough medicine (only over the counter and provided by parent) ____ Antibiotic ointment (topical)

**Please read the following information:**

A. The healthcare provider is a licensed nurse, responsible for assessing, evaluating, and referring the children. The child's physician is the only healthcare professional who can diagnose your child's illness/injury. Recommendations may be given by the healthcare provider based on his/her education and experience; however, the nurse is not responsible for the diagnosis of an injury/illness.

B. No treatment/care will be given to your child unless this form is on file. Parents will be contacted if an unexpected illness/injury occurs and this form is not on file.

C. If any of the emergency contacts or their numbers change throughout the school year, notification must be given to the school in writing.

D. **Medications will be administered very sparingly.** If your child has a medical condition that requires frequent administration of medication, please provide the nurse with the medication. Example: Frequent headaches and needs to receive Motrin. This includes **all** over the counter medication.

E. In the event of an illness/injury that threatens the child's life, limb, or vision, the situation will be considered an emergency situation and access to further healthcare (ambulance, family physician, emergency room, etc) will be immediately initiated and parent/guardian will be contacted as soon as possible.

After reading this medication policy, I hereby authorize the Marion Community Unit 2 School District healthcare provider, on my behalf, to administer the above medications in the manner described per the package directions. I further acknowledge and agree that when the medication is so administered, I waive any claims I might have against the school district and employees. I accept and will abide by the healthcare provider and medication policy instituted by Marion Community Unit 2 School District.

I have provided accurate and complete information and have read the above information and fully understand and agree. I also know that if I have any questions, I may contact the healthcare provider for further explanation.

_____ _____

Parent/Legal Guardian Signature Date