WILCO AREA CAREER CENTER

Prescription Medication Form

TO BE COMPLETED BY PARENT:

Student Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State ____ Zip _____

Parent(s)/Guardian Name(s) _____

Cell or Daytime Phone _____ Work Phone _____

Medication is required to be in its original container labeled with the child's name clearly indicated.
Parent(s)/Guardian(s) need to bring the medication to the main office. **This form will be part of your child's health record.**
Parent/Guardian must sign the Hold Harmless Agreement releasing all Wilco Area Career Center employees from all claims that may arise as a result of action or inaction resulting in the request herein made.

_____ _____

Parent/Guardian Signature Date

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TO BE COMPLETED BY PHYSICIAN:

Name of Medication _____ Dose _____ Frequency _____

Date of Prescription _____ Termination of Self-administration _____

Type of Illness _____ Why is medication needed? _____

_____

Is this Medication necessary to maintain the child in school? Yes _____ No _____

Is this child receiving additional medications? Yes _____ No _____

If yes, please list medication(s) _____

_____

Side effects or special instructions _____

_____

Physician's Name _____ Office Number _____

Address _____

(Street) (City) (State) (Zip)

_____ _____

Physician Signature Date

ADMINISTRATION USE ONLY

Administrator _____ Signature _____ Date _____