Log on back→

MEDICATION
PACT for West Central Illinois

Child: _____ Teacher: _____ Class: _____

1) Name of Medicine: _____Rx #_____ Expiration date ___/___/___

2) Dosage amount:_____Times: _____am/pm____am /pm_____am/pm Duration dates: __/__/__to__/__/__

3) Additional Instructions: _____

Physician name: _____ Phone # _____

_____
(Address) (City, state, zip)

Rx medication may be given without physician's signature as long as all information above is completed and medication is in original container properly labeled with child's name, RX #, duration and expiration dates, and directions.

NON-prescription medications or topical ointments may not be given without the information above AND a signature from the physician. Parents may take this form to physician to be completed, signed, and return to Teacher. A signed note from physician may be used but must contain all information above.

□ The above is **a NON-PRESCRIPTION MEDICATION**

Physician's Signature: _____ date: _____
(The above nonprescription medication may be given according to steps 1 to 3 above)

I give permission for PACT staff to carry out instructions above when my child is at PACT activities and for above listed physician to release to PACT all relevant information and records about my child's medication listed above for the purpose of treating my child while in PACT's classroom.
I understand that I may revoke this authorization by giving written notice. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the provider in reliance before I revoked it.
I understand that the information used or disclosed may be subject to re-disclosure by the agency receiving it and is no longer protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization requests it.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits from the provider releasing information (listed above).
I understand that this authorization is valid one year from the date signed, or until I revoke it in writing to the agency releasing information.

First dose of a medication may not be given at school. I (parent) verify the medication has been introduced to my child on (date) _____
Did or does child have any side effects from medication? YES, explain _____ NO

Parent Signature: _____ Date: _____

List child, duration, and expiration date on Classroom Alert List on Health & Safety Board
Log on back when medication is given. When medication is completed or no longer needed, medication will be returned to parent.

To be completed by staff
Where medication will be stored:
- ☐ Medication box, located: _____
- ☐ Refrigerator, located: _____
- ☐ Other - list any equipment needed that will not fit in box and where stored _____

_____
Staff person(s) designated to administer medication: _____

Copy: ☐ Site Sup. to review, initial, & send to C.O. _____ Original: ☐ Health & Safety Notebook Copy: DCFS file

LOG for MEDICATIONS

Child's Name: _____ Class: _____

Log below when medication is given. (Review with parent when unusual symptoms or reactions occur and at Parent Teacher Conferences. Parent sign and date when reviewed.)

Date	Time	Staff Name	Notes and Observations Log any unusual symptoms, reactions, or changes in child's behavior. If not given according to the duration date or instructions on front, make note of why below (i.e. child absent or weekend, holiday, etc.)	Date parent review	Parent Initials

☐ Complete for the year _____ _____

Teacher Signature Date

When complete for year, teacher signs off & gives to SS to place in DCFS file. SS will notify Health Coordinator by email that medication is complete and HC will take it off 3010 Report.

H 5/22