TO: PARENTS/GUARDIANS

FROM: QUEEN OF PEACE SCHOOL

RE: GIVING OR HELPING STUDENTS TAKE MEDICATIONS AT SCHOOL

The Following Is Required For *Prescription Medication*:

"...any non-injectable drugs, chemical compounds, suspensions or preparations which are taken either internally or externally by a student under the instruction of a physician."

1. Written instructions from **the doctor** which include:

- Name of student
- Name of medication
- dosage
- time to be given
- method of administration

2. It is **recommended** that the physician note any possible adverse reactions and action required. These instructions may be included on a prescription label or in separate written directions from the physician. "Take as directed" or "as needed" cannot be taken as specific direction.

3. **The Medication Authorization form must be signed and *completely* filled out by the parent or guardian.**

4. **All prescription medication must be in the prescription bottle, and clearly labeled.** ***(If the student is also taking the medication at home, the medication can be issued by druggist in two separate bottles.)***

5. **Unused medications must be picked up by parent or guardian** when treatment is complete or at the end of the school year. Medication left at school past the end of the school year will be destroyed.

The Following Is Required For *Non-Prescription Medication*:

"...only commercially prepared, non-alcohol based medication to be taken at school that is necessary for the student to remain in school. This shall be limited to eyes, nose and cough drops, dough suppressants, analgesics (pain relievers), decongestants, antihistamines, topical antibiotics, anti-inflammatories and antacids."

1. Written instructions from the **parent** which include:

- Name of student
- Name of medication
- dosage
- time to be given
- method of administration

2. All non-prescription medication **must be in original container or packaging.**

3. **Unused medications must be picked up by parent or guardian** when treatment is complete or at the end of the school year. Medication left at school past the end of the school year will be destroyed.

Additional *Authorization for Medication Administration* forms are available at the school office.

Authorization for Medication Administration by School Personnel

To:_____ of _____
Principal School Name

Student Name:_____DOB:_____ Grade:_____ Teacher:_____

I am giving school personnel permission to administer medications to my child per the following:
Parent or Physician please complete **(Remember to check appropriate boxes below)**:

Medication:

Dose(how much)

Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.

Route: (circle one)
By: Mouth Ear Eye Nose Skin Inhalation

Time to be given at school:

Duration: Start date_____end date_____

Reason for Medication:

Special Instructions:

☐ Non prescription

☐ Prescription Rx number_____

☐ Please allow my child to self-administer this medication. (refer to district policy on self-medication). *Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician. (See below)*

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature:_____Date:_____
(This authorization applies only to the medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

***PHYSICIAN DIRECTION**
(required in writing or on pharmacy label for all prescription medications).

☐ I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.
☐ Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer.)
☐ Special instructions including adverse reactions and action required:_____

_____

_____ _____
Physician's Name (please print/stamp) Address

_____

_____ _____ _____
Physician's Signature Phone # Effective Date

For use in Elementary and Secondary Archdiocesan Schools

Self-Medication Agreement for Prescription Inhalers

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription inhalers, subject to the following:

1. Self-administration of prescription inhaler requires permission from parent, school administrator and physician. Physician consent is to be included on the prescription label or on the medication consent form.

2. The inhaler must be kept in its appropriately labeled, original container, as follows:
   - Prescription inhaler label must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions. Physicians consent for self-administration is to be on the label or medication consent form.

3. **Sharing and/or borrowing of the inhaler with another student is strictly prohibited.**

4. **Permission to self-medicate may be revoked if the student violates Archdiocesan school policy governing administration of non-injectable medication and/or these regulations.**

I have read and agree to the above criteria and give permission for my child to carry

_____
(Name of Medication)

_____ _____
(Parent/Guardian Signature) *(Date)*

I agree to comply with the above criteria.

_____ _____
(Student Signature) *(Date)*

The student may carry and self-administer this medication as prescribed:

_____ _____
(School Administrator or designee) *(Date)*

This completed form must accompany the completed Authorization for Medication Administration by School Personnel form and must be kept in the school office.