LETTER TO PARENTS
MEDICATION POLICY

TO: Parents
FROM: School Health Clinic
DATE: ___________________________
SUBJECT: Medication Policy

To protect your child’s safety, the school nurse and/or health aide will adhere to the following medication policy. It is required that BOTH the parent AND physician signatures are on file before any prescription OR non-prescription medication is administered. This includes all medications including such over-the-counter products as Tylenol, Advil, Dimetapp, etc.

Although this may cause some inconvenience, we feel that this policy is best for the continued protection of your child, and must be followed. **If we do not have your written permission and the written permission of your physician, the medications will not be given.** Permission forms can be obtained by contacting your school nurse or health aide.

In order for your child to receive any medication at school, please conform with the following:

- A written request must be obtained from the physician and the parent/guardian. This request must include the name of the medication, dosage, time it is given during school hours, and duration. Forms are available at the school.

- The medication must be in its original container and, if an over-the-counter medication, the bottle must be new with an unbroken seal. All medications must have a fixed label which indicates the student’s name, name of medication, dosage, method of administration, time of administration and time interval of dosages.

- When the empty prescription bottle is returned to you, please bring the refill to school promptly.

- The medication and the signed permission form must be brought to the school by the parent or guardian.

- **PLEASE INCLUDE A PHOTO OF YOUR CHILD WITH THE PERMISSION FORM**

- New Request forms must be re-submitted each school year, and are necessary for any changes in medication orders.

- If your child is taken off medication or will no longer receive it at school, please put your request in a dated, written note as soon as possible. If the medication is not picked up by parents from the health aide or school office within 30 days, it will be properly disposed of.

- A signed Physician and Parent Request for the Administration of Medication by School Personnel is required in order to dispense medication.

Please contact the building principal or school nurse if you have any questions. Thank you for your cooperation.
PHYSICIAN AND PARENT REQUEST
FOR THE ADMINISTRATION OF MEDICATION
BY SCHOOL PERSONNEL

Student________________________________________________________________________
Address________________________________________________________________________
City/State/Zip____________________________________________________________________

Name of Medication and Dosage___________________________________________________
Times of Day to be Administered___________________________________________________

Number of Times/Intervals Medication is to be Administered__________________________
Date to Begin Medication____________________Date to End Medication________________

Adverse/Severe Reaction that Should be Reported to Physician
______________________________________________________________________________

Special instructions for Administration of Medication_______________________________

This medication can be safely administered by non-medical personnel_____Yes_______No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be
administered during school hours_____Yes_____No

This student is under my care. It is not possible to arrange for this medication to be taken at home under
the supervision of a parent and therefore must be taken during school hours.

___________________________________________      _________________________________
Physician’s Printed Name                                                                    Telephone

_______________________________________________      __________________________________
Physician’s Signature                                                                                   Date

Please regard my signature below as my assurance that I release Seton Catholic School, PSI, and any or
all of the school’s and PSI’s officers or employees from any liability or damages resulting from the
consequences or adverse reactions of our child’s taking or failing to take this medication at the times
prescribed. I also agree to keep the school informed in writing of any revision in the physician’s
prescription. I have had the opportunity to ask questions. They have been fully answered to my
satisfaction.

_______________________________________                      _______________________________
Parent’s Printed Name                                                                                   Date

8/2011