

## LETTER TO PARENTS MEDICATION POLICY

**TO: Parents**

**FROM: School Nurse**

**DATE:** \_\_\_\_\_

**SUBJECT: Medication Policy**

To protect your child's safety, the school nurse and/or health aide will adhere to the following medication policy. Beginning in August, 1996 it is required that **BOTH** parent's **AND** physician's signature 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 medication 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 doctor and the parent/guardian. This request must include the name of the medication, dosage, time it is given during school hours, and duration.
- The medication must be in its original container and have a fixed label which indicates the student's name, name of medication, dosage, method of administration and time of administration.
- When the empty prescription bottle is returned to you, please send the refill to school promptly.
- The medication and the signed permission forms must be brought to the school by the parent or guardian.
- Wherever possible, please include a photo of your child with the permission form.
- New permission 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 from the Health Aide or school office within 10 days, it will be properly disposed of.

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 it must be taken during school hours.

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Tel

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Please regard my signature below as my assurance that I release \_\_\_\_\_ 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

\_\_\_\_\_  
Tel

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date