MEDICATION ADMINISTRATION POLICY

In order to ensure student safety and health, St Joseph Catholic School has established a policy regarding the administration of medications during school hours.

If your child must be given medication of any kind during school hours, including over-the-counter medications, you have the following choices:

1. You, the parent/legal guardian, may come to the school and give the medication to your child
2. You may return the Authorization for Medication form located on the back of this paper. This form must be signed by the child's doctor/nurse practitioner and the parent/legal guardian. Once completed the form must be turned into the school's office with the medication. (Prescription drugs must be in the original container.)
3. You may choose to discuss the advisability with the child's doctor/nurse practitioner of giving the medication after school hours.
4. Students may not carry any medication prescription or over-the-counter either on their person or in their backpack. All medicine must remain in the nurse's office.

School personnel is prohibited from administering any type of medications whether prescription or over-the-counter unless they have the completed Authorization for Medication form on file. This form must be renewed every year.

If you have any questions, please check with the front office.

Thank you for your cooperation.

AUTHORIZATION FOR MEDICATION

The following section must be completed by the PARENT:

St. Joseph Catholic School
School ____________ Grade

Child's Name____________________ ____________ ________________
Last First Sex Date of Birth

____ ________________
Physician's Name Address Telephone

I understand that all medication taken by my child at school must be supervised by authorized school personnel.

__________ ____________________ ______________ ______________
Date Parent/Guardian Signature Home Phone Emergency Phone

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: ______________________________

Name of Medicine: ______________________________

Form: ______________________________

Dose: ______________________________

If medicine is to be given at school at what time? ______________________________

If Medicine is to be given "When needed" describe indications:

____

How soon can it be repeated? ______________________________

List significant side effects:______________________________

Length of time this treatment is recommended:______________________________

Other Information: ______________________________

Date: ______________ ______________________________
Physician's/Nurse Practitioner's signature