LETTER TO PARENTS

ADMINISTRATION OF MEDICATION IN SCHOOL

TO: **Parents/Guardian of** _____

FROM: **School Health Clinic and Principal**

DATE: _____

SUBJECT: **Administration of Medication in School**

As a school we understand that in order to be safe and able to benefit from the educational program, some students will need to take medicine at school. If your child must have medication of any type given during school hours, including over-the-counter drugs, you have the following choices:

- You may come to school and give the medication to your child at the appropriate time(s).
- You may obtain a copy of a medication form from the school nurse or secretary. (One medication per form.) Take the Physician and Parent Request for the Administration of Medication by School Personnel to your child's health care provider and have it completed by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. The prescriber for both prescription and over-the-counter drugs must complete this form. The health care provider and the parent must sign the form. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over-the-counter drugs must be received in the original, unopened container and will be administered according to the health care provider's written instructions.
- You may discuss with your health care provider an alternative schedule for administering medication (e.g., outside of school hours).

School personnel will not administer any medication to students unless they have received a form properly completed and signed by the prescriber, and the medication has been received in an appropriately labeled container. In fairness to those giving the medication and to protect the safety of your child, there will be no exceptions to this policy.

If you have questions about the policy, or other issues related to the administration of medication in the school, please contact the school nurse at the following number:

_____.

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's Signature Date