

# St. Joseph/Marquette Catholic School

## PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Whenever possible, the parent and physician should design a schedule for giving medication outside school hours. In the event that medication is prescribed to be given to a student during school hours the following policy must be followed:

- This form must be completed, signed and placed on file in the St. Joseph or Mother Joseph Center office.
- All medications must be kept in the designated office and placed under lock and key.
- All medication must be administered by the school nurse or designated school personnel.
- Parents are required to provide medication to the designated office and staff in the original container, labeled by the pharmacy or physician with the name of the medication, the amount to be administered and the time of day to be administered. When parents give medication to the office staff it must be counted and recorded by both persons.
- Medication maybe kept and self-administered upon physician authorization only.

### **BOTH PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS MUST FOLLOW THIS POLICY AS MANDATED BY STATE LAW**

Student name: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Diagnosis for which the medication is given: \_\_\_\_\_

Form or dose of medication: \_\_\_\_\_

What time is the medication to be administered: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_  
\_\_\_\_\_

Duration of this authorization: \_\_\_\_\_

The student is allowed by physician's order to have the above named medication on person and self-administered as prescribed: \_\_\_\_\_

Physician's signature is required

Physician or Dentist signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office address: \_\_\_\_\_ Office phone: \_\_\_\_\_

### **PARENT PERMISSION STATEMENT:**

I request that my child be allowed to take the prescribed medication as described above. The medication is to be furnished by the parent in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for reactions when the medication is administered in accordance with the physician's directions. This authorization is valid is limited to the duration as indicated above and not to exceed the current school year. In case of necessity the school may discontinue administration of the medication with proper notice. I am the parent or legal guardian of the child named on this form.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Student address: \_\_\_\_\_ Emergency phone: \_\_\_\_\_