MEDICATIONS: **GUIDE FOR PARENTS**

NO MEDICATIONS WILL BE GIVEN UNLESS ALL REQUIREMENTS ARE MET.

PRESCRIPTION MEDICATION

1) The school is required to have on file the written permission of the student's parent/guardian to give the medication. Use the form below or a note providing the student's name, name of the medication, dose, time to be given, reason to be given, and the parent/guardian signature with date.

2) The written order of a doctor is required. The prescription label meets this requirement. If your doctor had additional instructions they can be written on the form below or on a separate prescription note. **Remember- a new doctor prescription note is needed for all dosage changes!!**

3) All medication must be sent in the **ORIGINAL LABELED CONTAINER.** When filling a prescription, ask your pharmacist to provide one labeled container for home and one container for school use. This will greatly enhance receiving doses at both places at the prescribed times.

OVER-THE-COUNTER MEDICATION

If there is a parent/guardian authorization filed in the school office, one dose of an over-the counter medication (i.e. aspirin, Tylenol, etc.) in the **ORIGINAL LABELED CONTAINER** may be kept in the office for self-administration by the student.
Cough drops must be accompanied by a parent authorization and kept on the teacher's desk.

ALL MEDICATION AUTHORIZATIONS MUST BE RENEWED EACH SCHOOL YEAR!

SAINT PAUL CATHOLIC SCHOOL MEDICATION AUTHORIZATION

STUDENT NAME ______________________ **GRADE** __________

ALL MEDICATION MUST BE PROVIDED IN ORIGINAL LABELED CONTAINER

MEDICATION ________________DOSE_______TIME(S)______________

REASON FOR GIVING ____

DATE TO BEGIN ______________DATE TO END____________________

FOR PRESCRIPTION MEDS: Current prescription label or container OR doctor signature below.

Date______________**Doctor Signature**__________________**Phone**______________

PARENT/GUARDIAN AUTHORIZATION: Mark an (x) in appropriate space and sign below.

( ) I authorize the designee of St. Paul School to administer the medication as prescribed above

( ) I give permission for my child to self-administer the over-the-counter medication stated above.

Date ________**Parent/Guardian Signature**___________________**Phone**___________