

Dear Parents,

Questions have been raised about the administering of medication to children during school hours. It is most important that parents and children understand the Academy's policy regarding medications.

The policy states: "UNDER NO CIRCUMSTANCES SHOULD ANY SCHOOL EMPLOYEE ATTEMPT TO SUGGEST A DIAGNOSIS OR PRESCRIBE OR GIVE MEDICINE OF ANY KIND, INCLUDING ASPIRIN, TO A STUDENT."

If it is absolutely essential that medication be administered at school, the following are necessary:

1. Written permission from the student's parent or guardian must be on file in the school office.
2. Written statement from the doctor must be on file in the school office. This must include:
 - Student's name
 - Medication to be administered
 - Amount to be given
 - Time to be given
 - Duration of treatment
 - Physician's signature
3. Medication must be in the original container from the pharmacy, clearly marked with the student's name, dosage, and time to be given.

The parent/doctor permission slip is available through the school office and IS REQUIRED FOR ALL MEDICATIONS, INCLUDING OVER-THE-COUNTER ITEMS SUCH AS ASPIRIN, COLD REMEDIES, COUGH MEDICINES, EYE DROPS, OINTMENTS, ETC. It is the responsibility of the parent to secure the information from the physician along with the required signature.

These precautions are necessary as a safeguard for all children. Your cooperation and understanding are appreciated.

PERMISSION FORM FOR PRESCRIBED MEDICATION

Date form received by the school: _____

Student: _____ Date of Birth or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physicians or authorized prescriber

Name of medication: _____

Reason for medication (Optional): _____

Form of medication/treatment:

____ Table/capsule ____ Liquid ____ Inhaler ____ Injection ____ Nebulizer ____ Other

Instructions (Schedule and dose to be given at school): _____

Start: _____ date form received Other dates: _____

Stop: _____ end of school year Other date/duration: _____

_____ For episodic/emergency only

Restrictions and/or important side effects: _____ None anticipated

_____ Yes, Please describe: _____

Special storage requirements: _____ None _____ Refrigerate

Other: _____

This student is both capable and responsible for self-administering this medication:

_____ No _____ Yes-Supervised _____ Yes-Unsupervised

This student may carry this medication: _____ No _____ Yes

Please indicate if you have provided additional information:

_____ On the back side of this form _____ As an attachment

Date: _____ Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to the school policy.

Date: _____ Signature: _____ Relationship: _____