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 of 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***:**
_____ Tablet/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:____________________