

REGULATIONS ON THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

A. GENERAL POLICY

1. No pupil shall be given medications during school hours except upon the written request from a licensed physician who has the responsibility for the medical management of the pupil. All such requests must be signed by the parent or guardian.

B. RESPONSIBILITIES OF THE PARENTS OR GUARDIANS

1. Parents or guardians will assume full responsibility for supplying all medications to the school Healthroom.
2. No medications may be brought to school by pupils, or kept in a pupil's possession.
3. Parents or guardians shall deliver any medication to be administered under the provisions of this policy to the school office or school Healthroom.

C. RESPONSIBILITY OF THE PHYSICIAN

1. A request form for each prescribed medication must be completed by the pupil's physician, signed by the parent or guardian, and filed with the school administrator and school nurse.
2. The container must be clearly labeled with the following information:
 - Pupil's full name
 - Physician's name
 - Physician's telephone number
 - Name of medication
 - Dosage, schedule and dose form
 - Date of expiration of prescription
3. Each medication is to be in a separate container labeled as above.

D. RESPONSIBILITY OF SCHOOL PERSONNEL

1. Pupils taking medication will be assisted by authorized school personnel. This shall be done in accordance with the physician's instructions.
2. All medications administered by school personnel must be kept locked in a secure place.

Rev. 5/01

See reverse side for Form No.PPSD-5 "REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS."

2002-03 Nurses Request for Meds during School

DIVISION OF INSTRUCTION
 DEPARTMENT OF PUPIL PERSONNEL SERVICES
 HEALTH SERVICES

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

TO BE COMPLETED BY PARENT: (please print)

_____ St. Bruno Catholic School
Last Name of Pupil *First Name* *Sex* *Date of Birth* *School*

I request that my child, named above, be assisted in taking the prescribed medication at school by authorized persons, and will comply with the school's policies and procedures.

_____ _____ _____
Date *Telephone #* *Signature of Parent/Guardian*

TO BE COMPLETED BY A LICENSED PHYSICIAN: (please print)

_____ _____
PURPOSE OF MEDICATION *NAME OF MEDICATION*

_____ _____ _____
DOSAGE PRESCRIBED *TIME SCHEDULE* *DOSE FORM (TABLET, LIQUID, ETC.)*

_____ _____
DATE OF PRESCRIPTION *LENGTH OF TIME THIS MEDICATION WILL BE NECESSARY*

Precautions, Special Instructions, Possible Adverse Effects, Comments

The pupil named above, for whom this medication is prescribed, is under my care.

_____ _____
Print name of Physician *Signature of Physician*

_____ _____ _____
Address *Telephone* *Date*

**MUST BE RENEWED
 EACH SCHOOL YEAR**

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