

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**

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