APPENDIX 2 4.1

Parental Consent for Prescription and Over the Counter Medication Administration in School

Child's Name: _____ **DOB:** _____
School: _____ **Date:** _____

My child is to receive _____ medication at _____
according to the physician's directions for _____.

This treatment will last _____.
My child has _____ allergies.

Prescription medications must come to school in the original container with the label stating the pharmacy name and phone number. The label must also include the child's name, name of the medication, time the medication is to be given, dosage, route the medication is to be given, date of expiration, and the licensed healthcare provider's name and phone number.

Over the counter medication must be labeled with the child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in the original container. Herbal medications and nutritional supplements are considered in the same category as OTC medications.

By signing this document, I give permission for this medication to be administered to my child at school. The school has my permission to call the prescribing healthcare provider with any questions regarding the medication.

I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representatives, from liability that may arise from administering medication to my child.

Print Parent / Guardian Name: _____ Date: _____

Signature: _____

Home phone: _____

Cell Phone: _____

Work phone: _____

Please ask the pharmacist for a separate medicine container to keep at school. Thank you!

APPENDIX 6

Parental Consent for Student to Carry and Self Administer Medication
Parent / Student Contract

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

My child may carry with him/her and self administer his/her own medication. I realize that the school is not responsible for the benefits or consequences of the medication. The school bears no responsibility for assuring that the medication is taken. I also understand that if my child abuses the policy of carrying his/her medication, the medication will be confiscated and the privilege will be taken away.

Name of medication: _____

Reason for taking medication: _____

My child has _____ **allergies.**

Student Contract

( ) I plan to keep the above named medication with me at school rather than in the school office.

( ) I agree to use this medication in a responsible manner, in accordance with my physician's orders.

( ) If this is an inhaler, I will notify the school office if I am having more difficulty than usual with my asthma.

( ) I will not share my medication with others.

Student's Signature: _____ Date: _____

Parent / Guardian

This contract is in effect for the current school year unless revoked by the physician or my student fails to meet the above safety contingencies.

( ) I agree to see that my child carries his/her medication as prescribed, that the container contains medication, and the date is current.

( ) I will review the status of my child's medication with my child on a regular basis.

If my child uses an inhaler or has an Epi-pen, I will provide a back up spare to be kept in the school office. _____ Yes _____ No

Parent/ Guardian's Signature: _____ Date: _____