Medication Permission Form

Student_____ DOB_____
School _____ Grade_____

Policy for students receiving medication at school whether prescribed medication by a physician or authorized prescriber or over the counter medication is as follows:

- Signed orders from the parent/guardian and physician must be on file
- Over-the-counter medication brought in the original container
- Prescribed medication with a pharmacy label that matches the written orders
- All medication must be brought to the school by the parent
- School personnel may refuse to give the medication

To be completed by the Physician or Authorized Prescriber:

Reason for the medication: _____
Name and strength of medication: _____
Form of Medication:

☐ Tablet/capsule	☐ Liquid	☐ Inhaler	☐ Injection	☐ Other

Amount and Time/s: _____
For PRN state the frequency, the time between dosages of medication, and maximum number of dose in a school day: _____
_____
Start date for medication: _____
End date for medication: _____ (All orders will be valid for the current school year.)
Additional information, instructions, restrictions and/or important side effects:
_____
_____
Physician's or Authorized Prescriber Signature _____ Date_____
Physician's or Authorized Prescriber name (print): Name _____
Phone Number _____ Fax number_____

To be completed by the Parent/ Guardian:

I instruct the school principal or the principal authorized personnel to give the medication as instructed above.
Do you want to be called before or after a PRN medication is given? Yes___ No____
Additional information/instructions or restrictions _____
_____

Consent

I hereby request that the medication specified above be given to the above named student. I understand that the school personnel who give the medication may not be a medically trained person.
I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/ Guardian Signature _____ Date _____
Printed name_____ Relation to the child _____
Special forms are required for severe allergies and administration of Epipens, administration of diabetic medication, and self-administration and carrying of asthma medication.

SCHEDULED AND "AS NEEDED" (PRN) MEDICATION PERMISSION

Only necessary medication (prescribed for, but not limited to the treatment of: ADD/ADHD, Asthma, Diabetes, and Epilepsy) may be given at school. All medication should be given outside of school hours, if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. Should school personnel refuse to give medication, the parent/guardian is informed and the incident documented. If necessary, medication can be given at school only under the following conditions:

1. If medication is needed in order for a student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the nurse or principal designee.
2. All necessary medication prescribed for a student must be signed by a physician, dentist, physician assistant, podiatrist, or nurse practitioner and parent/guardian. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. "Over-the-counter" medication must be in its original labeled container and have the student's name on the bottle. Medications sent in baggies or unlabeled containers will not be given. "Over-the-counter" include ointments and eye drops and may not be given without a physician and parent signature.
3. It is the responsibility of the parent/guardian to bring all medication to the clinic/office and to pick up unused medicine. Any medicine unused that is not picked up will be destroyed.
4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements, and other nutritional aids not approved as medication by the FDA will not be administered at school.
5. Only antibiotics prescribed to be taken four times a day with noon, as one of those times will be dispensed.
6. Medications must be kept in locked cabinet/drawer in the school office/clinic and administered in the school office/clinic. Unless other considerations are made.
7. A student may need medication in a school-related event. The principal is to authorize a school employee to administer medication. The medication must be in the original container, a photocopy of the parental permit, and the time(s) the medication is to be given.
8. Only the **school nurse** can give nebulizer treatments in school. Non-licensed school personnel are not permitted to administer this treatment. The parent must come to school to give the treatment if there is no nurse.
9. No one-time medication such as an antibiotic or sedative will be given.
10. Complete the "As-Needed Medications, Special Medication or Treatment" section for medications that are "prn" any other route other than oral and for special treatments needed.
11. Special forms must be filled out for emergency medications such as those for allergies. A special form must be filled out when a student is to carry asthma medication.

SCHOOL: _____

NAME OF STUDENT: _____ ROOM: _____ GRADE: _____

NAME OF MEDICATION
and STRENGTH _____

DOSAGE: _____ TIME(S) _____
ROUTE _____ DIRECTIONS FOR GIVING _____

BEGINNING DATE: _____ ENDING DATE: _____

AS-NEEDED MEDICATION, SPECIAL MEDICATION OR TREATMENT SECTION

A. Circumstances warranting requested PRN treatment/medication:

1. Condition requiring treatment/medication: _____
2. Signs and symptoms of condition: _____
3. Signs and symptoms that require medication and/or treatment to be given. _____
4. Length of time signs and symptoms present to warrant treatment/medication: _____

5. Related signs and symptoms of condition which constitute a medical emergency for which EMS and parent called:

_____

6. Maximum number of treatments per school day not to exceed: _____

7. Additional instructions/comments: _____

8. Supplies needed _____ Amount _____

C. Skills required to administer treatment/medication: _____

D. Method of administration of treatment/medication: _____

E. Additional instructions/comments: _____

F. This medication may/may not be carried by school personnel to school-related events or off-campus events.

Beginning Date: _____ End Date: _____

SIGNATURE OF PHYSICIAN: _____ DATE: _____
(STAMPED SIGNATURE NOT ACCEPTED)

PRINTED NAME: _____

PHYSICIAN'S TELEPHONE NUMBER: _____

Parent or Guardian

I want to be called: ___Before giving the medication ___After medication is given ___Other

Comments or information:

I hereby request that the medication specified above is given to the above named student and that someone may give the medication other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/ GUARDIAN: _____ DATE: _____