St. Edward High School
13500 Detroit Avenue, Lakewood, Ohio 44107-4697
Phone: 216-221-3776 Fax: 216-221-4609 www.sehs.net

Letter To Parents
Medication Policy

To: Parents
From: School Health Clinic
Date 2012-2013 School Year
Subject: **Medication Policy**

To protect your son's safety, the school nurse and/or health aide will adhere to the following medication policy. It is required that **BOTH** the parent **AND** physician signatures are on file before any prescription **OR** non-prescription medication is administered. This includes all medication including such over-the-counter products as Tylenol, Advil, and Maalox.

Although this may cause some inconvenience, we feel that this policy is best for the continued protection of your son, and must be followed. **If we do not have your written permission and the written permission of your physician, the medication will not be given.** Permission forms can be obtained by contacting your school nurse.

In order for your child to receive any medication at school, please conform with the following:

- A written request must be obtained from the physician and the parent/guardian. This request must include the name of the medication, dosage, time it is given during school hours, and duration. Forms are available at the school.
- The medication must be in its original container and if an over-the-counter medication, the bottle must be new with an unbroken seal. All medications must have a fixed label, which indicates the student's name, name of medication, dosage, method of administration and time interval of dosages.
- When the empty prescription bottle is returned to you, please bring the refill to school promptly.
- The medication and the signed permission form must be brought to the school by the parent/guardian
- New Request forms must be re-submitted each school year, and are **necessary for any changes in medication orders.**
- If your son is taken off medication or will no longer receive it at school, please put your request in a dated, written note as soon as possible accompanied by a physician's signed order to discontinue the medication. If the medication is not picked up by parents from the school clinic or school office within 30 days, it will be properly disposed of.
- A signed **PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL** form is required in order to dispense medication. Only **ONE** medication per request form.

State Law allows students to carry on their person, **ASTHMA INHALERS or EPI-PENS** when prescribed by a physician. If your son needs to carry an inhaler or has severe allergy, appropriate forms **MUST** be filled out, signed by a physician and parent/guardian and be on file in the clinic. Please call the clinic for the appropriate forms at 216-221-3776, extension 227.
Please contact the building principal or school nurse if you have any questions. Thank you for your cooperation.

June Durrant, R.N. Renie Miller, R.N.

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PHYSICIAN AND PARENT PERMISSION/ REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student_____ Grade_____

Address_____

City/State/Zip_____

Name of medication _____Dosage_____

Times of Day to be Administered_____

Number of Times/Intervals Medication is to be Administered_____

Date to Begin Medication_____ Date to End Medication_____

Adverse/Severe Reaction that Should be Reported to Physician_____

Special Instructions for Administration of Medication_____

This medication can be safely administered by non-medical personnel [ ] yes [ ] no

It is impossible to arrange for this medication to be taken at home and, therefore, it must by administered during school hours. [ ] yes [ ] no

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

_____ _____
Provider's Name Printed Name Tel

_____ _____
Provider's Signature Date

Please regard my signature below as my assurance that I release **St. Edward High School**, **PSI**, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____
Parent's Printed Name Tel

_____ _____
Parent's Signature Date