NOTRE DAME HIGH SCHOOL
MEDICATION POLICY

Connecticut State Law requires that students who receive medication in school have a written order on file at school. The attached form must be completed by the health care provider and signed by the parent/guardian. All medication orders must be renewed annually. Any change in the order will require a new written form.

Medication will be given only if the effectiveness depends on administration during school hours.

All medications administered in school must be:

1. Brought to school by parent/guardian, responsible adult or eligible student (age 18 or older).
2. In the original pharmacy container.
3. Given to school nurse.
4. In the absence of the school nurse, qualified school personnel may accept medication. However, the school nurse must review orders and containers before medication can be given. You will be contacted if all requirements have not been met.
5. Accompanied by a signed order from an authorized prescriber and parent/guardian or eligible student.
6. **The initial dose of any new medication must be given at home.**

Any over the counter medications must follow this policy. The container must be a new unopened one. No more than a 3 month supply will be accepted. Unused medication must be picked up by a parent or responsible adult before the last day of school or it will be destroyed.

You may, of course, come to school and administer the medication yourself.
Call if you have questions.

Thank you for your cooperation.

Sincerely,

Elaine Durso RN
School Nurse
Notre Dame High School
1 Notre Dame Way
West Haven, CT 06516
Phone: 203-937-3233 ~ Fax: 203-933-2474

School Health Department Procedure

School Nurse may not administer:

1. Medications in excess of standard protocols.
2. Narcotics for pain.

School: **Notre Dame High School** **Grade: _____**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law and Regulations require an authorized prescriber's (physician, dentist, optometrist, advanced practice registered nurse, or physician's assistant and for interscholastic and intramural athletic events only, a podiatrist) written order and parent or guardian's authorization for a nurse to administer medications or, in the absence of the nurse, qualified school personnel to administer medications. Medications must be in the original properly labeled container and dispensed by a physician or pharmacist.

PRESCRIBER'S AUTHORIZATION

Name of Student _____Date of Birth: _____

Condition for which drug is being administered: _____

Drug/generic name: _____ Dose: _____ Route: _____

Time of administration: _____ Frequency, if PRN: _____

Relevant side effects: [ ] None expected [ ] Yes (Specify): _____

ALLERGIES: [ ] NO [ ] YES (Specify): _____

Medication shall be administered from (date) _____to (date) _____

Medication needed for Field Trip: _____yes_____no **Medication to be given on half day: _____yes _____no**

Prescriber's Name/Title: _____ Phone #: _____ Fax #: _____

Address: _____

Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 3 month supply of medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or the last day of school, whichever comes first. I grant permission for the school nurse to exchange information with this prescriber regarding the administration of this medication.

Parent/Guardian's Signature: _____ Date: _____

Telephone (home) _____(work) _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of a medication **may** be authorized by the prescriber and parent/guardian for **certain** medications. Authorization **must** be presented to the school nurse in accordance with Board policy and district nursing protocols.

Prescriber's authorization for self-administration: [ ] Yes [ ] No _____ Date: _____
(signature)

Parent/Guardian authorization for self administration:[ ] Yes [ ] No _____ Date: _____
(signature)

School nurse approve for self administration [ ] Yes [ ] No _____Date: _____
(not required for inhalers or cartridge injectors) (signature)