

Notre Dame Preparatory High School

LIST ONLY ONE MEDICATION PER FORM

Student's Name: _____ Name of Medication: _____

Dosage: _____ Frequency: _____ Time to be given: _____

Start Date: _____ Stop Date: _____ Reason: _____

Allergies to medications: _____

RX Number: _____

Notre Dame Preparatory Medication Policy

- All medication needed during school hours will be dispensed by the nurse, administrator, or designated school office staff.
- All medications, both prescription and non-prescription **must be in the original container.**
- **All over-the-counter medications must be provided by the parent/guardian in the original, small, sealed container. (No more than 24 count).**
- No medication will be administered without the written consent of the parent/guardian
- This form is only good for the current school year for which it is signed.
- **To safeguard our students, all medication, both prescription and non-prescription must be brought into the nurse's office by a parent or guardian, or an adult appointed by the parent or guardian.**
- No student shall be permitted to carry medication on their person. Exceptions to this rule are inhalers and Epi Pens which have a separate form.
- Any unused medication which is unclaimed by the parent will be destroyed by school personnel when a prescription is no longer to be administered or at the end of the school year.
- No over the counter products that are not FDA approved will be dispensed during school hours. This includes vitamins, enzymes and homeopathic medication

I give permission to the school nurse to share with the prescribing physician information relative to this medication administration (i.e. effectiveness, adverse side effects) as she/he determines necessary for the health and safety of my child. I authorize the school nurse or school personnel, under the supervision of the school nurse, to be my agent to give the above medication to my son/daughter: I further agree to hold the above-designated person harmless in any and all claims arising from the administration of this medication at school.

Parent/Guardian Signature

Date

Home phone: _____

Cell phone: _____

Nurse