LETTER TO PARENTS
ADMINISTRATION OF MEDICATION IN SCHOOL

TO: **Parents/Guardian of _____**

FROM: **School Health Clinic and Principal**

DATE: **_____**

SUBJECT: **Administration of Medication in School**

As a school we understand that in order to be safe and able to benefit from the educational program, some students will need to take medicine at school. If your child must have medication of any type given during school hours, including over-the-counter drugs (depending on the school/district policy), you have the following choices:

- You may come to school and give the medication to your child at the appropriate time(s).

- You may obtain a copy of a medication form from the clinic staff or secretary. (One medication per form.) Take the Prescriber and Parent Request for the Administration of Medication at School to your child's health care provider and have it completed by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. The prescriber for both prescription and over-the-counter drugs (depending on school/district policy) must complete this form. The prescriber and the parent must sign the form. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over-the-counter drugs must be received in the original, unopened container and will be administered according to the written instructions.

- You may discuss with your prescriber an alternative schedule for administering medication (e.g., outside of school hours).

School personnel will not administer any medication to students unless they have received a form properly completed and signed by the prescriber and the parent, and the medication has been received in an appropriately labeled container. In fairness to those giving the medication and to protect the safety of your child, there will be no exceptions to this policy.

If you have questions about the policy, or other issues related to the administration of medication in the school, please contact the clinic staff at the following number:

_____.

Thank you for your cooperation.

PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

***** One Medication per Form *****

Student Photo

School DePaul Cristo Rey High School.

Student _____ Grade/Rm_____

Address _____

City/State/Zip _____

Name of Medication and 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 be 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.

_____ _____

Prescriber's Printed Name Tel

_____ _____

Prescriber's Signature Date

Please regard my signature below as my assurance that I release _____ _____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