ST. THOMAS AQUINAS
CATHOLIC SCHOOL

Prescribed Medication Permit Form

Only necessary medication for chronic illnesses or acute conditions may be given at school. All medication should be given outside of school if possible. Unless otherwise recommended by the student's physician, three times a day medications should be given before school, after school, and at bedtime for optimal coverage. If necessary, prescription medication can be given at school under the following conditions:

1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the medical professional, and returned with the medication to the school nurse or health clinic.
2. If circumstances dictate that necessary prescription medication must be taken by the student while at school, such medications must be prescribed for a student by a doctor, dentist, or Nurse Practitioner, and the student must provide this Prescribed Medication Permit Form signed by the medical professional and parent.
3. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. Medications sent in baggies, unlabeled, or relabeled containers will not be given.
4. The parent or high school student is responsible to bring all medications to the clinic/office and pick up unused medicine or it will be destroyed. Medication will not be kept year to year.
5. Experimental medications/dosages, herbal medications, dietary supplements, and other nutritional aids not approved as medications by the FDA will not be administered at school.
6. High school students are responsible for remembering to come to the clinic for regularly prescribed medications. It is NOT the responsibility of the nurse or staff.
7. All medications must be kept in a locked cabinet/drawer in the school clinic and administered ONLY in the clinic. Medications should not be in the possession of the student.
8. Students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler should also be kept in the clinic for use. No other students are to be in possession of a different student's inhalers.
9. Only the school nurse and/or the high school student or parent may perform nebulizer treatments in school. Non-medical school personnel is not permitted to administer this treatment.

To the Nurse:

Student Name:		
Grade	**Dosage**	**Duration of request ___/___/___to___/___/___**
Medication	**Route of administration**	**Time to be given**
Indication and directions for medication:		
Medical Professional Name	**Address**	**Phone Number**

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I, the parent/guardian named below, hereby request that the medication specified above be given to the above-named student by school personnel and that the medication may be given by someone other than a medically trained person as designated by the school-administrator

I realize that the school does not agree to allow medications 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 convenience and the student's benefit. Such agreements by the school are adequate consideration of my agreements herein. I agree to indemnify and hold harmless the Diocese of Dallas, 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 of 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 Diocese of Dallas, its servants, agents, or employees, including, but not limited to the parish, the school, the principal, and the individuals giving or failing to give the medication.

Parent/Guardian Signature	**Date**
Parent/Guardian Name	
Medical Professional Signature (stamped signature not accepted)	**Date**
Medical Professional Name	**Phone Number**