

## *Espirito Santo Parochial School*

143 Everett Street, Fall River, MA 02723    Rev. Maurice O. Gauvin, Pastor  
Tel: (508) 672-2229    Fax: (508) 672-7724    Mr. Andrew J. Raposo, Principal  
[www.espiritosantoschool.org](http://www.espiritosantoschool.org)    [www.facebook.com/EspiritoSantoSchool](http://www.facebook.com/EspiritoSantoSchool)

Dear Parent/Guardian,

We would like to inform you of the state regulations governing the administration of all medications administered in school. These policies have been put in place to ensure the health and safety of children needing medications during the school day.

These regulations require that the following forms must be on file in your child's health record before we begin to give any medication in school:

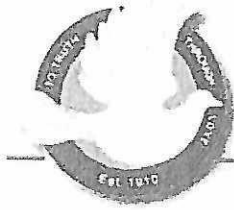
1. **Signed consent by the parent or legal guardian to give the medication.** Please complete the consent form and return to your school nurse;
2. **Signed medication order.** The written medication order form should be taken to your child's licensed prescriber (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be renewed as needed **and** at the beginning of each academic year.

Medications should be delivered to the school in a pharmacy or manufacturer-labeled container **by you or a responsible adult whom you designate.** Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty-day supply of the medication should be delivered to the school, along with a note stating the number of pills sent in to school.

When your child needs medication to be given during the school day, please act quickly to follow these policies so we may begin to give the medication as soon as possible. **It is recommended that medication be administered at home.** However, students who **must** receive medication during the school day are required to comply with the above regulations.

No over-the-counter medication will be given in school without the required signed medication forms.

If you have any questions, please contact the school nurse. Thank you for your help.



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## Medication Order Form

(to be completed by a licensed prescriber)

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_  
(street) (city/town)

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Medication \_\_\_\_\_

Route of administration \_\_\_\_\_ Dosage \_\_\_\_\_

Frequency \_\_\_\_\_ Time(s) of Administration \_\_\_\_\_  
(Please note: Whenever possible, medication should be scheduled at times other than school hours).

Specific directions or information for administration: \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Diagnosis\* \_\_\_\_\_

Any other medical condition(s)\* \_\_\_\_\_

### Additional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:

\_\_\_\_\_

2. Other medication being taken by the student: \_\_\_\_\_

\_\_\_\_\_

3. The date of the next scheduled visit or when advised to return to prescriber: \_\_\_\_\_

4. Consent for self-administration (provided the school nurse determines it is safe and appropriate).

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature of Licensed Prescriber

\*if not in violation of confidentiality.



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## Parent/Guardian Authorization for Prescription Medication Administration

Student's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian printed name \_\_\_\_\_

Telephone number—Home \_\_\_\_\_ Cell Phone number \_\_\_\_\_

Telephone number—Work \_\_\_\_\_

Telephone number—Emergency \_\_\_\_\_

Other person(s) to be notified in case of emergency if parent/guardian is unavailable:

Name \_\_\_\_\_ Telephone number \_\_\_\_\_

Relationship \_\_\_\_\_

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

My son/daughter has the following food or drug allergies:

I consent to have the school nurse or school personnel designated by the School Nurse administer the following medication(s) \_\_\_\_\_

prescribed by \_\_\_\_\_ to \_\_\_\_\_

Licensed Prescriber

Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate. \_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission to the School Nurse to share information relevant to the prescribed medication administration, e.g., adverse side effects, as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature \_\_\_\_\_

Relationship to Student \_\_\_\_\_ Date \_\_\_\_\_