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 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 _____