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 Parents,

In accordance with the laws of the Massachusetts Department of Public Health, if your child requires the administering of medication during school hours, it is necessary to submit a prescription order from your child's physician to the school office along with the medication. Medications must be in their original package from the pharmacy with the child's name and dosage clearly visible.

An **Authorization for Dispensing Medication** form must also be signed by both the physician and parent or guardian.

Over the counter medications such as acetaminophen, ibuprofen, antacids and cough drops are not allowed to be in your child's possession or backpacks during school hours. OTC medications will not be administered to your child under any circumstances without prior completion and signing of the **Authorization for Dispensing Medication** form as stated above.

Phone authorization will not be accepted.

*****Without proper documentation and authorization, the school reserves the right to contact you to come to the school to administer prescribed medication to your child.*****

Thank you,

Mr. Andrew Raposo
Principal

DIOCESE OF FALL RIVER DEPARTMENT OF EDUCATION

AUTHORIZATION FOR DISPENSING MEDICATION

Parent or Guardian

I request that my son/daughter _____,

Grade _____, a student at Espirito Santo Parochial School receive medication as prescribed by

Dr. _____ in the form stated below.
(Physician's Name)

The medication is to be furnished by me as designated in the medication policy of the Diocese of Fall River, Department of Education.

I understand that the school is rendering a service and does not assume any responsibility in this matter.

Parent/Guardian Signature _____

Date _____ Phone Number _____

Whenever possible, medication should be given at home and every effort made to avoid school hours.

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Physician

I request that my patient receive the following medications:

Name of Pupil _____ D.O.B. _____

Name of Medication _____ Dosage _____

Diagnosis _____

Time and method to be taken during school hours _____
Expected duration of treatment _____
Possible side effects and adverse reactions _____
_____
Other recommendations _____

Physician's Signature _____

Date _____ Phone Number _____