Dear Parents/Guardians:

The health "status"of a student bears a direct relationship to the quality of the student's educational achievements. To maintain an optimum health status for learning, some students may require medication. The administration of medications in the schools is governed by state law. In accordance with the law, Central Catholic High School has enacted the following guidelines:

1. In compliance with Diocesan policy, medication and signed permission forms shall be brought to the school by the parent/guardian. At no time shall a student of any age be permitted to carry medication to school unless authorized in writing by the parent and/or physician.
2. All medication is to be taken in the clinic or in a designated area.
3. The form on the reverse side of this sheet must be completed and signed by parent/guardian before the medication can be administered in school.
4. If medication is prescribed by a physician, this form must also be signed by that physician.
5. Medication must be picked up by parent at end of school year.

Thank you for your time and concern in helping us provide optimal health care to your son/daughter.

Respectfully,

Jennifer Paul RN

Mrs. Jennifer Paul, RN
School Nurse

JP/tg

# CENTRAL CATHOLIC HIGH SCHOOL

## SCHOOL HEALTH SERVICE

### Request for Administration of Medication to Student

Student's Name _____ Grade _____

Address _____

| Medication Prescribed | Time to be taken | Dosage to be administered | Date to begin | Date to end |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Reason for Medication: _____

Severe adverse reactions which should be reported to the doctor: _____

_____

Special Instructions: _____

_____

Self-administered ____YES ____NO

Physician's Signature _____

Physician's Emergency Telephone Number _____

Date _____

I hereby request that _____ be given the medication described above.
(student's name)

***I understand that the <u>medication must be sent in the container in which it was dispensed by the prescribing physician or a licensed pharmacist. Medication cannot be given until this form is completed and returned</u> to the school nurse. I agree to submit another completed form if any of the above information changes.**

Parent/Guardian Signature _____

Date _____

==========

FOR SCHOOL USE ONLY

Received by _____ Date _____

Unused medication returned to parent. Parent signature/Date _____