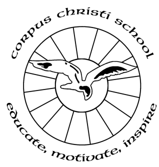


REGULATIONS REGARDING THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1) GENERAL POLICY

a) No student shall be given medications during school hours except upon the written request from a licensed physician who has the responsibility for the medical management of the student. All such requests must be signed by the parent or guardian.

b) Permission forms for students to receive medications (both prescription and non-prescription) while at school must be renewed each academic year.

2) RESPONSIBILITY OF THE PARENTS OR GUARDIANS

a) Parents or guardians will assume full responsibility for the supplying of all medications.

b) No medications may be brought to school by students.

c) Parents or guardians shall deliver or cause to be delivered by an adult or an authorized employee of a pharmaceutical supplier, any medication to be administered under the provisions of this policy.

3) RESPONSIBILITY OF THE PHYSICIAN

a) A request form for each prescribed medication must be completed by the student's physician, signed by the parent or guardian, and filed with the school administrator or their designated representative.

b) The container must be clearly labeled with the following information:

   i) Pupil's full name

   ii) Physician's name

   iii) Physician's telephone number

   iv) Name of medication

   v) Dosage, schedule and dose form

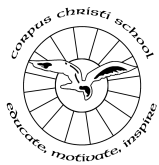
   vi) Date of expiration of prescription

4) RESPONSIBILITY OF SCHOOL PERSONNEL

a) Pupils taking medication will be assisted by authorized school personnel. This shall be done in accordance with the physician's instruction.

b) All medications administered by school personnel are maintained in a locked and secure place.

Updated August 2018



CHILD'S LAST NAME: ____

PRESCRIPTION AND/OR NON-PRESCIPTION MEDICATION PERMISSION FORM

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS BY A STUDENT

TO BE COMPLETED BY PARENT:

LAST NAME OF STUDENT FIRST NAME SEX DATE OF BIRTH

I request that my child, named above, be assisted in taking the following medication at school by authorized CCS personnel, and that he/she shall comply with the school's policies and procedures.

DATE SIGNATURE OF PARENT/GUARDIAN TELEPHONE

PREFERRED NON-PERSCRIPTION MEDICATION – if any - (TYLENOL, ADVIL, ETC.) TO BE GIVEN DOSAGE

TO BE COMPLETED BY A LICENSED PHYSICIAN FOR *PRESCRIPTION MEDICATION*:
(ONLY for prescription medication to be taken at school)

NAME OF STUDENT

PURPOSE OF MEDICATION NAME OF MEDICATION

DOSAGE PRESCRIBED TIME SCHEDULE DOSE FORM (TABLET, LIQUID, ETC.)

DATE OF PRESCRIPTION LENGTH OF TIME TO BE TAKEN

Precautions, Special Instructions, Possible Adverse Effects, Comments:

The student named above, for whom this medication is prescribed, is under my care.

PRINT NAME OF PHYSICIAN SIGNATURE OF PHYSICIAN

ADDRESS TELEPHONE

PERMISSION FORM MUST BE RENEWED EACH SCHOOL YEAR
SEPARATE FORM NEEDED FOR PRESCRIPTION MEDICATION FOR EACH STUDENT

Updated August 2018