# LETTER TO PARENTS
# MEDICATION POLICY

**TO:** Parents/Guardian of _____

**FROM:** School Health Clinic

**DATE:** _____

**SUBJECT:** Medication Policy

To protect your child's safety, the clinic staff will adhere to the following medication policy. It is required that **BOTH** the parent **AND** prescriber signatures are on file before any prescription **OR** non-prescription medication (depending on the school/district policy) is administered. This includes all medications including such over-the-counter products as Tylenol, Advil, etc.

Although this may cause some inconvenience, we feel that this policy is best for the continued protection of your child, and must be followed. **If we do not have your written permission and the written permission of your prescriber, the medication will not be given.** Permission forms can be obtained by contacting the clinic staff.

In order for your child to receive any medication at school, please conform with the following:

- A written request must be obtained from the prescriber and the parent/guardian. This request must include the name of the medication, dosage, time it is given during school hours, and duration. Forms are available at the school.
- A signed Prescriber and Parent Request for the Administration of Medication at School is required in order to dispense medication.
- The medication must be in its original container and, and if an over-the-counter medication, the bottle must be new with an unbroken seal. All medications must have a fixed label which indicates the student's name, name of medication, dosage, method of administration, time of administration and time interval of dosages.
- When the empty prescription bottle is returned to you, please bring the refill to school promptly.
- The medication and the signed permission form must be brought to the school by the parent or guardian. **Students may not bring medication to school.**
- Please include a photo of your child with the permission form.
- New Request forms must be re-submitted each school year, and are **necessary for any changes in medication orders.**
- If your child is taken off medication or will no longer receive it at school, please put your request in a dated, written note as soon as possible, accompanied by a prescriber's signed order to discontinue the medication. If the medication is not picked up by parents from the health aide or school office within 30 days, it will be properly disposed of.
- Medication will not be administered without a signed order from the prescriber or Prescriber and Parent Request for the Administration of Medication at School.

Please contact the building principal or clinic staff if you have any questions. Thank you for your cooperation.

# PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

***** One Medication per Form *****

Student Photo

School _____.

Student _____ Grade/Rm_____

Address _____

City/State/Zip _____

Name of Medication and Dosage _____

Times of Day to be Administered _____

Number of Times/Intervals Medication is to be Administered _____

Date to Begin Medication _____ Date to End Medication _____

Adverse/Severe Reaction that Should be Reported to Physician _____

Special Instructions for Administration of Medication _____

This medication can be safely administered by non-medical personnel ☐ Yes No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours ☐ Yes No

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

_____ _____

Prescriber's Printed Name Tel

_____ _____

Prescriber's Signature Date

Please regard my signature below as my assurance that I release _____ _____ School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Printed Name Tel

_____ _____

Parent's Signature Date