DIOCESE OF SPOKANE MEDICATION REQUEST

Dear Parent/Guardian,

According to state law, St. Mary's Catholic School may permit school personnel to dispense medication at school only when the following requirements are met:

1. A medication request form must be completed for each student receiving any kind of prescription or non-prescription medication at school. It must be signed by the child's parent/guardian and by a physician, dentist, or a licensed health professional prescribing within the scope of his/her prescriptive authority, must be current and unexpired, and must be valid for a period not to exceed one school year.

2. Any medication required for fifteen or more consecutive school days must be accompanied by current written instructions from a physician or dentist for dispensing the medication.

3. All medication must be supplied and delivered to the school by the parent/guardian.

4. All medication must be in a properly labeled container.

   A. Prescription medication must be in a container labeled by a physician, dentist, a Licensed health professional prescribing within the scope of his/her prescriptive authority, or pharmacist, and brought to school by the child's parent or guardian. The label shall include student's name, physician's or dentist's name, name of medication, dosage and time of day to be taken.

   B. Non-prescription medication must be brought to school in its original container.

5. Each school will provide the means for safekeeping and secure storage for all medication. If special conditions are required to maintain the quality of the medication, the school will adhere to the instructions of the physician/dentist/pharmacist.

6. Medication will be dispensed in the school office.

7. No medication requiring injection shall be administered by school personnel except in extreme circumstances, determined by the physician and the parent/guardian.

8. Medications will be dispensed only by authorized school personnel. A medication record shall be maintained for any student receiving medication at school.

9. Medications shall be returned directly to the parent/guardian when no longer required or at the end of the school year. Any unclaimed medication must be destroyed.

10. In the event that the building administrator considers it necessary to discontinue dispensing medication, the student's parent/guardian will be notified in advance.

11. Adult-age students who have medication dispensed from the school office may sign the medication request form.

DIOCESE OF SPOKANE

MEDICATION REQUEST FORM

(A separate form must be filled out for <u>*each*</u> medication)

Please Note: This form must be completed and signed by the physician, dentist, or a licensed health professional prescribing within the scope of his/her prescriptive authority and the parent for prescription medicine.
Only parent/ signature is required for "over-the-counter", non-prescription medications.

This form is for both prescription and non-prescription medication.

PARENT REQUEST

STUDENT NAME: ____

SCHOOL: ____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to dispense medication to the above identified student in accordance with the prescription or doctor's instructions for the period commencing with the __________ day of __________________________, 20 ____ through
the __________ day of ______________________________, 20 ____. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

________________________ SIGNATURE: ______________________________________
Date of Signature

TELEPHONE NUMBER: _____________________________
Home / Work

PHYSICIAN / DENTIST REQUEST

PHYSICIAN/DENTIST/ LICENSED HEALTH PROFESSIONAL PRESCRIBING WITHIN THESCOPE OF HIS/HER PRESCRIPTIVE AUTHORITY REQUEST

MEDICATION (Name, Dosage): ____

ADMINISTRATION SCHEDULE: ____

REASON FOR MEDICATION: ____

FURTHER INSTRUCTIONS (possible reactions, etc): This section must be completed if medication is to be dispensed for more than 15 days. ______________________________
____

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above for the period commencing with the _______ day of ________________________, 20 ___ through the _______ day of ________________________, 20 ___ as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

___________________ ____
Date of Signature — Physician's, dentist's, or a licensed health professional prescribing within the scope of his/her prescriptive authority Signature

Continued on next page...

Child's Name: ______________________ Medication: ______________________

(A separate form must be filled out for each medication)

HOW TO GIVE MEDICATION:

☐ By mouth ☐ On the skin ☐ Breathe ☐ As a shot

HOW TO STORE MEDICATION:

☐ Refrigerate ☐ Not Refrigerated ☐ Locked box

Parent provided measuring device for liquid/by mouth medication: ☐

PARENT PLAN OF ACTION IN EVENT MEDICINE IS NEEDED:

EXAMPLE ONLY: Call parents immediately. Administer age appropriate dose of Benadryl first to see if symptoms retreat. Call 911 and administer EpiPen only if symptoms do not retreat and/or breathing becomes extremely distressed and/or other symptoms indicate that anaphylactic shock may be setting in.

Please list your own set of instructions below.

____

____

____

____

____

NO HEALTH CHANGES

Must be signed by parent/legal guardian ***every 90 days.***

If there are health changes A new form must be completed and signed by Dr.

Parent Signature:______________________________ Date:__________________

Parent Signature:______________________________ Date:__________________

Parent Signature:______________________________ Date:__________________

Parent Signature:______________________________ Date:__________________

This side for school use only.

MEDICATION RECORD

NOTE: This record must be retained until the student is 21 years of age.

Student Name ____________________________________ **Birth Date** ________________________ **Date** __________________

Date Medication Received __________________________ **By Whom** ____

Name of Medication ____ **Dosage** ________________________ **Time of Day** _____________

The above medication was dispensed at ____ **School as follows:**

DATE	TIME	SIGNATURE	DATE	TIME	SIGNATURE	DATE	TIME	SIGNATURE

Medication was: ______ **Returned to (Parent/Guardian)** _________________________________ **/ Date** ____________________