

Saint Michael School
80 Maple Avenue
North Andover, MA 01845



Phone (978) 686-1862
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st-michael@comcast.net
www.saintmichael.com

MEDICATION ADMINISTRATION PACKET

Dear Parent / Guardian:

I would like to inform you of the policies in place to ensure the health and safety of children requiring medication during the school day.

It is the policy of Saint Michael School to administer medication during school hours only when the prescribed schedule cannot be met outside of school hours.

Saint Michael School requires that the following forms must be on file in your child's health record before we begin to give any medicine at school:

1. **Signed doctor's medication order.** The written medication order form (Form B) should be taken to your child's licensed prescriber (physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be provided before the medication can be administered. *For short term medications, the prescription label will suffice as doctor's order.
2. **Signed consent by the parent or guardian to give the medicine.** Please complete the attached consent and administration information form (Form C) and deliver it to the school nurse. No medication will be given without this form on file.

Additional parent responsibilities:

- Please provide a photograph of your child to help ensure positive identification of your child for medication administration.
- **You or a responsible adult whom you designate (never with a child)** must deliver medication directly to the nurse- if nurse is not available, you may leave medication with Mrs. Donahue, our receptionist or administration. **Medication must be in a pharmacy or manufacturer-labeled container.** (Please note: Medications will not be administered that arrive loose in baggies.)
*****Helpful hint: If medication is a prescription, please ask your pharmacy to provide separate bottles for school and home. If this is impossible, please bring in label to health office for label to be copied for our records.
- Any changes must be accompanied by a doctor's order and reported to the health office as they occur.

If your child needs a medication to be given during the school day, please act quickly to follow these policies so we may begin to give the medication as soon as possible.

Thank you for your help and cooperation in this important matter.

Best regards and stay healthy, Linda Sullivan, RN

Attachments: Doctor's Order- Form **B** and Written Parent / Guardian Consent and Administration Plan- Form C

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DOCTOR'S ORDER/LICENSED PROVIDER
REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

I, the undersigned prescriber, request that the school nurse or other designated person administer the medication I have prescribed below. I certify that failure to administer the medication may jeopardize the health of my patient.

Student name: _____ Date of birth: _____

Address: _____

Parent/Guardian: _____

Provider Name (Please print): _____

Address: _____ Telephone #: _____

Diagnosis of student: _____

Other medical conditions: _____

Other medications taken by student: _____

Name of medication being prescribed: _____ **Dose:** _____ **Route:** _____

Frequency _____ **Time(s) to be administered:** _____ **Discontinuation date:** _____

Specific directions or information for administration: _____

Possible side effects of medication: _____

Any restriction of school activity? No ___ Yes ___ (Please specify: sports, lab, gym, etc) _____

Signature of licensed provider: _____ Date of order: _____
(Please note-All orders must be renewed yearly.)

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PARENTAL/GUARDIAN CONSENT AND MEDICATION ADMINISTRATION PLAN

Name of Student: _____ Date of Birth: _____ Grade: _____
Diagnosis: _____ Allergies: _____
Other Medications taken by student: _____
Name of Licensed Prescriber: _____ Business Phone: _____

***I give my permission to have the school nurse or designated school personnel give the following medication to my son or daughter during school hours. (Please note-orders must be renewed yearly.)

Name of Medication: _____ Start Date: _____ End Date: _____
Dosage: _____ Route: _____ Frequency: _____ Time: _____

- Any specific directions: _____
- Possible side effects of medication: _____
- Medication tracking: (This must be filled out if medication is a controlled substance.)

Date						Date	
Quantity						Quantity	
Rec'd by						Retrieved by	
Delivered by						Discarded by	

- Required Storage conditions: _____
- Plan for monitoring medication/condition, if needed: _____
- Plan for field trips: _____

Please answer the following:

*I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration, e.g. adverse side effects, as she/he determines necessary for my son's/daughter's health and safety. ___ YES ___ NO

*I understand that I may retrieve the medicine from the school at any time and that the medicine will be discarded if it is not picked up within one week following termination of the order or on the last day of school. ___ YES ___ NO

*I consent to having forms for this medication filed in my child's health record. ___ YES ___ NO

*I wish forms for this medication kept separate from my child's health record. ___ YES ___ NO

Parent/guardian signature: _____ Date: _____

Nurse signature: _____ Date: _____