

August , 2009

Dear Parents:

Attached is the permission form needed before the school nurse or health aide may administer medication to your child.

Both the physician and the parent must print and then sign their names on the enclosed form before any prescription medication or over-the-counter drugs may be given to any child.

The request must include instructions as to the name of the medication, dosage, time and duration of the medication.

The medication and the signed permission form must be brought to the school clinic by the parent/guardian.

Medication must be in the original container (child proof) and have an affixed label including the student's name, name of the medication, dosage, route of administration and time of administration by school personnel. A small school picture (1 1/2 x 2") or a small forward face pose must also be included with the medicine.

If you have any questions or need an additional form, please call the school clinic at 440-842-6818 Ext. #3107.

Sincerely,

Mrs. Jan Cicerchi
Principal

Form attached

**PHYSICIAN AND PARENT REQUEST
FOR THE ADMINISTRATION OF MEDICATION
BY SCHOOL PERSONNEL**

Student _____

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.

Physician's Printed Name

Telephone

Physician's Signature

Date

Please regard my signature below as my assurance that I release Incarnate Word Academy 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

Telephone

Parent's Signature

Date