Greenwich Junior-Senior High School

"Building on a Tradition of Excellence"

Phone 692-9542 ext 4222 Fax 692-8503

Medication Administration In School

School nurses **cannot** administer prescription **or** non-prescription medications to a student without the following:

1. Written directions from the prescribing physician regarding the administration of the medication.
2. Written permission from the parent/guardian for the school nurse to administer the medication.
3. Medication must be in the original container with the child's name on it.

Physician's directions and parent/guardian permission must be renewed each school year. This form should be completed by physician and parent/guardian. The physician may choose to use his/her own letterhead, but the basic information must be provided. **Parent/Guardian permission and physician's directions must be received before any medication will be administered in school**. All medication turned over to the school is kept under lock and key. **Students will not carry medication with them, at any time, unless written authorization is received from the physician. Our preference is for all medication to be kept in the Health Office.**

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A.	**TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:**
	I request that my patient, as listed below, receive the following medication:
	Name of Student: Date of Birth:
	Diagnosis:
	Name of Medication
	Prescribed Dosage, Frequency and Route of Administration:
	Time to be Taken During School Hours:
	Duration of Treatment:
	Possible Side Effects and Adverse Reactions (if any):
	Other Recommendation:
	The child named above has been instructed ion the proper use of the medication noted. We request that the child be permitted to carry the medication on his/her person or to keep same in his/her locker or PE locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use. **student may carry medication** **keep medication in nurse's office**
	Name of Licensed Prescriber and Title (please print):
	Prescriber's Signature: Date:
	Address: Phone:
B.	**TO BE COMPLETED BY THE PARENT OR GUARDIAN:**
	I request that my child _________________________, grade _____, receive the medication as prescribed above by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication unless indicated as self-carry above by the physician.
	Signature (Parent or Guardian):
	Address:
	Telephone: Home _______________ Work _______________ Cell _______________ Date: ____________________