ARCHDIOCESE OF LOS ANGELES DEPARTMENT OF CATHOLIC SCHOOLS

Parent Notification for the Administration of Medication at School

To the Parent/Guardian:

Medical treatment is the responsibility of the parent(s)/guardian and family physician. Medications, **both prescription and over the counter**, are rarely given at school; the only exceptions involve special or serious problems where it is deemed absolutely necessary by the physician that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's physician, to work out a schedule of giving medication at home, outside of school hours, whenever possible.**

In the event that it is necessary to administer medication during school hours, school personnel will assist in carrying out the physician's recommendations. Medication will be stored in a secure location, as defined by school policy.

If medication is to be administered at school, <u>all</u> of the following conditions must be met:

- Completion of an authorization form for the administration of medication at school by both the parent and physician. This must include the condition for which the medication is to be given, name, dosage, routine, and specific instructions for emergency treatment.
- Medication must be delivered to the school and picked up by the parent/guardian or other responsible adult.
- Medication must be in a pharmacy-labeled container or a sealed and labeled package. Loose unlabeled pills will not be accepted. (Ask the pharmacy to provide a second labeled container for school use)
- An appropriate measuring device must accompany all liquid medication.
- A separate form is required for each medication.
- Additional authorization forms are required for inhalers and diabetic management.

This request is valid for the duration of one academic year. Whenever there is a change in medication, dose, time, the parent(s)/guardian and physician must complete a new form.

Thank you in advance for your cooperation.

ARCHDIOCESE OF LOS ANGELES MEDICATION AUTHORIZATION AND PERMISSION FORM

One form per medication

Part A, B & C to be completed by a licensed Physician
Part D by parent/guardian – please print

A.				
	Last Name of Student	First Nam	e	Grade
	Name of Medication		Purpose of Medication	
	Dosage	Frequency (times to be admir	nistered at school)	Dose form (tablet/liquid)
	Length of time this medication will be necessary			
В.	Physician's Recommendations. (Please check where applicable.)			
	Please notify this office if patient misses medication at school.			
	Medication may have adverse effects (explain)			
	Special instructions and/or comments			
C.	Physician's Authorization: The student for whom this medication is prescribed is under my care.			
	Printed Name of Licensed Physician		Signature of Licensed Physician	
	Physician's Telephone Number		Date	
D.	Permission for Medication to be Taken During School Hours			
	request that my child,, be permitted to receive and to be assisted / supervised in taking the above prescribed medication at school. I will comply with the policies and procedures determined by the Department of Catholic Schools.			
	Date Days	time Telephone	Primary Emergency Contact Number	
			Signature of Parent/Guardian	