

## MEDICATION PERMISSION FORM

According to the Indianapolis Archdiocesan Policy on Administration of Medication and Medical Care children are not permitted to carry medication on their persons, with the exception of inhalers for asthma and other respiratory conditions. See Medication Policy in the Parent Student Handbook. Children are not permitted to carry non-prescription medications including vitamin supplements, acetaminophen ibuprofen, cough drops, etc.

It is the responsibility of the parents to discuss with their physicians an arrangement in which the need to give medication at school can be avoided. If the administration of medicine at school can absolutely not be avoided, the medication must be brought to the school office **by the parent/guardian**. Prescribed medicine must be sent in the original pharmaceutically dispensed and labeled container with instructions for administration. All non-prescription medication must be delivered to the school office, in the container in which it was purchased, **by the parent/guardian**. Receipt of the medication will be logged into a confidential medical log. The medication must also be accompanied by the written permission form below completed by the parent/guardian allowing non-medical staff to oversee administration of the specific medication. **MEDICATION WILL NOT BE GIVEN WITHOUT THE INFORMATION BELOW.**

Name of Student: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Diagnosis or Reason the medication is to be taken: \_\_\_\_\_

\_\_\_\_\_

The appropriate dose, method of administration (i.e. by mouth) and specific instructions (i.e. take with food, etc.): \_\_\_\_\_

\_\_\_\_\_

The time or times a day medication should be taken: \_\_\_\_\_

The start date of the medication: \_\_\_\_\_

The number of days the medication is to be taken: \_\_\_\_\_

Any known side effects of the medicine and / or symptoms of the condition being treated or intolerance to the medicine (i.e. previous known side effects, etc.) \_\_\_\_\_

\_\_\_\_\_

I give my permission to the non-medical staff of St. Lawrence School to oversee the administration of the above medication to my child, \_\_\_\_\_, per the written instructions above.

Parent / Guardian Name (Please print): \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_