Policy for Administration of Medication

Dear Parent / Guardian:

According to the State Health Code, including the State Board of Nurse Examiners, the school nurse **may not administer** any prescription medication without a written order from your child's physician indicating the name of the medication, the dosage, the reason it is being given and the time to administer it in school. ***Your signature is also required***.

Also, the school nurse is **not permitted to administer** non-prescription medications (over-the-counter or patent medications) without a physician's written permission. The name of the medication, the dosage, the reason and the time to be administered must be included in the permission statement. ***Your signature is also required***.

In order for the school nurse to administer prescription medications, St. Aloysius Parish School requires that you ask your physician to complete the enclosed form. In the event your child needs non-prescription medications, fill in the name of the medications below and ask your doctor to sign it. Have your child return the form to the school nurse. Medications must be labeled properly – including the date, the name of the student, the name of the medication, the dosage, the reason it is being given and the time to administer it.

The school nurse will be glad to administer medications in keeping with the State of Pennsylvania regulations upon you and your physician's completion of the "Permit to Administer Medication" form. ***Phone permission is not acceptable***. Thank you for your cooperation in this important matter.

Non-Prescription
Permit to Administer Medications
(Signed permit good for current school year only)

Student Name: _____ Homeroom: _____

Name of Non-Prescription Medication: _____

Strength of Medication: _____ Amount to be given: _____

Dates to be given: _____ Time to be given: _____

_____	_____	_____
Signature of Parent / Guardian	Phone Number	Date
_____	_____	_____
Signature of Physician	Phone Number	Date

Prescription
Permit to Administer Medications
(Signed permit good for current school year only)

Student Name: _____ Homeroom: _____

Name of Non-Prescription Medication: _____

Strength of Medication: _____ Amount to be given: _____

Dates to be given: _____ Time to be given: _____

_____	_____	_____
Signature of Parent / Guardian	Phone Number	Date
_____	_____	_____
Signature of Physician	Phone Number	Date