OFFICE OF CATHOLIC SCHOOLS
ARCHDIOCESE OF CHICAGO

SCHOOL MEDICATION PROCEDURES

Parents/guardians have the primary responsibility for the administration of medication to their children. The administration of medication to students during regular school hours and during school related activities is discouraged unless necessary for the critical health and well being of the student.

It is the policy of this school that school personnel, including teachers, administrators, administrative staff, shall not administer medication to students except as provided in the School Medication Procedures established for the administration of medication.

Compliance with the School Medication Procedures established for the administration of medication is the responsibility of the parent/guardian.

Procedures

1. Medication Authorization Form. No school personnel shall administer any prescription or non-prescription medicine unless a complete Medication Authorization Form for such student has been received by the School Principal or his/her designee. No student shall be allowed to possess or consume any prescription or non-prescription medication unless a complete Medication Authorization Form for such student has been received by the School Principal or his/her designee.

Medication Authorization Forms are available at the school office. In addition, a **Medication Authorization Form** is distributed for each student at the time of enrollment. A **Medication Authorization Form** is complete if it contains the following information:

a. A written prescription issued by a physician, dentist or other licensed prescriber. The prescription must set forth the child's name, licensed prescriber's signature and telephone number, medication name and dosage, and date of order;

b. Written administration instructions written by the licensed prescriber setting forth the route, time or intervals of administration, and the duration of the prescription;

c. Written indication, on the medication or by separate notation of the licensed prescriber, of the diagnosis requiring medication, intended effects and possible side effects of the medication; and,

d. Written permission and authorization for the administration of medication signed by the student's parent/guardian.

2. Appropriate Containers. It is the responsibility of the parent/guardian to provide the school with all medication in appropriate containers. Only medication for which a complete Medication Authorization Form has been received by the School Principal or his/her designee shall be allowed in the school. All such medication shall be provided in containers which are:

a. Prescription-labeled by a pharmacy or licensed prescriber (displaying Rx number, student name, medication, dosage, direction for administration, date and refill schedule, pharmacy label, and name/initials of pharmacist) or

b. Manufacturer-labeled for non-prescription over-the-counter medication.

3. Administration. Administration of medication means dispensing, distributing, or adherence to the route by which the medication is to be administered indicated on the completed Medication Authorization Form.

Medication will not be administered to any student by any school personnel unless the complete Medication Authorization Form contains the written request and authorization of a parent/guardian to have the School Principal or his/her designee, or school nurse (if applicable), administer such medication to the student, and the School Principal or school nurse (if applicable) has agreed in writing to administer the medication as set forth in the complete Medication Authorization Form. Such written agreement by the School Principal or school nurse shall be indicated on the completed Medication Authorization Form. The School Principal, or school nurse, retains the right to deny such requests to administer medication to the students provided that such denial is indicated on the completed **Medication Authorization Form.**

Parents/guardians must make other arrangements for the administration of medication to students, such as arranging for medication to be administered before or after school or having the parent/guardian come to the school to administer medication, if:

a. A completed **Medication Authorization Form** has not been received and approved by the School Principal for the medication sought to be administered; or

b. A request and authorization for the administration of medication is denied by the School Principal or school nurse; or

c. The medication identified in the completed **Medication Authorization Form** is not given the School Principal in an appropriate container as described herein.

4. Self-Administration. A student may self-administer medication at school if so ordered by his or her licensed prescriber. Except as provided in Section 6, below, such medication must be stored in a locked cabinet under the control of the School Principal or his/her designee and a completed **Medication Authorization Form** must be received by the School Principal. The completed **Medication Authorization Form** must contain a written statement signed by the licensed prescriber and the parent/guardian verifying the necessity and the student's ability to self-administer the medication appropriately.

Except as provided in Section 6, below, self-administration of medication shall be under the supervision of the School Principal or his/her designee or the school nurse (if applicable).

5. **Storage of Medication.** Medication received by the school in accordance with a completed **Medication Authorization Form** and in an appropriate container shall be stored in a locked cabinet. Access to the locked cabinet shall be limited to the School Principal and his/her designees, and the school nurse (if applicable).

Medication requiring refrigeration shall be stored in a refrigerator that cannot be accessed by students and shall be kept separate from food items.

At the end of the school year, or the end of the treatment regime, the student's parent/ guardian will be responsible for removing any unused medication from the school. If the parent/guardian does not pick up the medication by the end of the school year, the medication will be appropriately discarded by the School Principal.

6. **Carrying and Unsupervised Self-Administration of Medication.** Students who suffer from asthma or allergies that require the immediate use of medication shall be permitted to carry such medication and to self-administer such medication without supervision by school personnel only if the following conditions are met:

a. A completed **Medication Authorization Form** has been received by the School Principal or his/her designee or by the school nurse (if applicable).

b. A completed **Physician Request for Self-Administration of Medication** form has been completed by the student's physician and parent/guardian and received by the School Principal or his/her designee or by the school nurse (if applicable).

7. **Emergency Medical Care.** In the event a student shall become ill or injured or otherwise need immediate medical attention that is not contained in the **Medical Authorization Form** on file with the School Principal or his/her designee or with the School nurse (if applicable), the Principal or his/her designee shall attempt to contact the student's parent/guardian utilizing the information provided on the student's **Medical Information and Emergency Notification Form**. If the student's parent/guardian cannot be contacted, the School Principal or his/her designee shall attempt to contact the person identified by the parent/guardian as the student's emergency contact. In either event, such contact shall be made to advise of the observed illness or injury or need for medical attention and to obtain further instructions from the student's parent/guardian or emergency contact.

Notwithstanding the foregoing, the School Principal or his/her designee or School nurse (if applicable) or other certified school personnel may call State or local emergency medical services before or after attempting to call the student's parent/guardian or emergency contact if, in the exercise of school-related supervision of the student, the student's illness, injury or need for immediate medical attention is perceived to be in need of emergency medical care.

MEDICATION AUTHORIZATION FORM

_____ SCHOOL, _____, ILLINOIS

Student's Name (Last, First, Middle	Date of Birth	Grade	Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned the following to the School Principal or his/her designee:

X Medical Authorization Form

X Unsupervised Self-Administration Request Form (if the student is to carry and use medication on his/her own during school hours or during school activities)

X Medication in the original labeled container as dispensed (Prescription medication) or the manufacturer's labeled container (Non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Physician's Order

Medication/ Health Care Treatment	Dosage	Time(s) to be administered

Intended effect of this medication

Expected side effects, if any

Other medications the student is taking

May student self-administer medication under supervision of school personnel who do not have medical training?

(Please circle) YES NO

Administration Instructions

Discontinue Re-evaluation Follow-up (Please Circle): _____ Date

Physician's /Prescriber's Signature

Date Signed

Physician's/ Prescriber's Name

Emergency telephone number

Address

City , State, Zip Code

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and Non-prescribed medication in the manner described in the Physician's Order {Reverse side}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

_____ _____

Parent/Guardian's Signature **Date signed**

_____

Parent/ Guardian's Name

_____

Address

_____

City, State, Zip Code

_____

Home telephone

_____

Business telephone

Medication Authorization Approved this ____ day of _____, 200__.

_____

School Representative's Signature

On behalf of _____ School, _____, Illinois.

Physician Request for Self-Administration of Medication

Name of Student _____ Date of Birth _____

To:

Principal, _____, School, _____, Illinois:

The above named child has _____
Name of Illness or Medical Condition

I am requesting that the above-named student be allowed to take the following medication during school hours or during school-related activities:

Name of Medication _____ Type of Medication (tablet, liquid, capsule, inhaler, injectable) _____

Dosage _____ Time(s) to be taken or administered _____

Possible side effects _____

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision. (Circle One):

Yes No

For ASTHMA and ALLERGY CONDITIONS ONLY: I also request that this student be allowed to carry the above-described medication on their person during school hours and during school related activities in order facilitate the self-administration of the medication as needed. (Circle One):

Yes No

Signature of Physician _____ Date _____

Name of Physician _____

Address _____ Emergency telephone number _____

City, State _____

Last Name, First Name, MI

Grade

FOR OFFICE USE ONLY

Medical Information and Emergency Notification Form

Academic Year _____

_____ _____

Student's name (Last Name, First Name, Middle Initial) Date of Birth

I hereby acknowledge that I have received and read the School Medication Procedures. I understand that I am primarily responsible for all medical decisions regarding my child and that under the School Medication Procedures, and that the administration or self-administration of medication to my child will not be allowed unless I have complied with the requirements of the School Medication Procedures.

_____ has the following medical conditions:

(Student's name)

_____

_____

In case of an emergency involving this student, please contact:

_____ _____

Parent or Guardian Daytime telephone

_____

Other telephone

Other Emergency Contact:

_____ _____

Individual Daytime telephone

_____ _____

Relationship to Student Other telephone

X_____ _____

Signature of Parent/Guardian Date