FORM 8

STUDENT MEDICATION AUTHORIZATION

ARCHDIOCESE OF WASHINGTON – Catholic Schools

NOTE: THIS RELEASE AND INDEMNIFICATION AGREEMENT IS NOT AN AUTHORIZATION FOR AN EPI-PEN OR INHALER

PART I: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Sex: ☐ ☐ Birth Date: _____
Print Student's Name Male Female *mm/dd/yyyy*

School's Name: _____ School Year: _____

Allergies: _____

Medication: ☐ Renewal ☐ NEW If new, the first full dose must be given at home to assure that the student does not have a negative reaction.

First dose was given: Date _____ Time _____

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the Archdiocese of Washington Catholic Schools Policies and district or state guidelines.
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication Authorization forms are required for each Prescription and Over-The-Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school**.
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    - Student name
    - Date of Birth
    - Diagnosis
    - Signs or symptoms
    - Name of medication to be given in school
    - Exact dosage to be taken in school
    - Route of medication
    - Time and frequency to give medications, as well as exact time interval for additional dosages
    - Sequence in which two or more medications are to be administered
    - Common side effects
    - Duration of medication order or effective start and end dates
    - LHCP's name, signature and telephone number
    - Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    - Name of student
    - Exact dosage to be taken in school
    - Frequency or time interval dosage is to be administered

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PART I: TO BE COMPLETED BY PARENT/GUARDIAN (CONTINUED)

12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student. Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

I hereby request designated <<Type School's Name Here>>, personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the Archdiocese of Washington, the parish, school, personnel, employees, or agents from lawsuits, claim expense, demand or action, etc., against them for helping my child use this medication. I have read the procedures outlined above and assume responsibility as required.

Name of Parent/Guardian: _____ Home Phone: ( ) -

Signature of Parent/Guardian: _____ **Date** _____

PART II: TO BE COMPLETED BY PARENT/GUARDIAN FOR OCCASIONAL OVER-THE-COUNTER (OTC) MEDICATION.

NOTE: **LICENSED HEALTHCARE PROVIDER (LHCP) MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS AND OTC'S ADMINISTERED FOR FOUR (4) OR MORE DAYS).**

<<Type School's Name Here>> discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined above. Information should be written in lay language with no abbreviations.

Diagnosis: _____ Signs/Symptoms: _____

Medication: _____ Route: _____

Dosage to be given at school: _____ Times/Intervals: _____

Effective Date: Start _____ End _____ If student is taking more than one medication at school, list sequence in which medications are to be taken: _____

Name of Licensed Healthcare Provider: _____ Phone: ( ) -

Signature of LHCP: _____ Date _____

Name of Parent/Guardian: _____ Phone: ( ) -

Signature of Parent/Guardian: _____ Date: _____

PART III: TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if Part II is written on the LHCP stationery or a prescription pad).

☐ Medication is appropriately labeled. _____Date by which any unused medication is to be collected by the parent (Within one week after expiration or on the last day of school)

Signature of Principal/Nurse: _____ Date _____

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