

Immaculate Conception School

1208 East McCarty Street
Jefferson City, Missouri 65101
Phone: 573-636-7680
Fax: 573-635-1833

A Note About Medications To Be Given at School:

1. The school does not have any medication on hand for students. Only medications brought in and accompanied by a completed "Permission for School Administration of Medication" form may be given to a student.
2. Parents must fill out a "Permission for School Administration of Medication" form for each medication. This form must be filled out every year or when any changes are made.
3. All medications must be in the original container.
4. Prescription medications, to be given at school, should be accompanied by the completed "Permission for School Administration of Medication" form, a physician prescription, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. (Pharmacy will provide an extra medication bottle when asked.)
5. Nonprescription (over the counter) medications must be appropriate for the age of the student and in the appropriate dosage as listed on the container/bottle.
6. It is suggested that all medications administered to your child be approved by his/her doctor.
7. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed by the prescribing physician that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.
8. The very first dose of any medication should not be given in school, as it is unknown how the student will react to the medication.
9. Medications may be left at school for use throughout the school year as needed. Again this must be supplied from home and accompanied by the completed "Permission for School Administration of Medication".
10. All medications are to be stored in the First Aid Office, not carried by students.

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Permission for School Administration of Medication

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school.

Prescription medications to be given at school **should be accompanied by this form, a physician prescription, and provided to the school in the original labeled container** provided by the pharmacist who filled the prescription.

Nonprescription (over the counter) medications **should also be accompanied by this form, and provided to the school in the original labeled container.** It is suggested that all medications administered to your child be approved by his/her doctor.

NOTE: The school does not maintain a supply of any medications.

(“Sample” medications must be provided in a container that appropriately identified the medication and must be accompanied by a note signed by the prescribing physician that includes the student’s name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.)

Student’s Name:	Grade:	Date of Birth:
Medication:	Dosage (Amount):	
Purpose of medication:	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Other _____	
Time of day medication is to be given at school:	Is medication only to be given as needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Anticipated number of days medication will be given at school: <input type="checkbox"/> until end of current school year <input type="checkbox"/> _____ days <input type="checkbox"/> _____ weeks	Note any special storage requirements for medication <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other (specify)	
	Is student allergic to any foods, medicines or other items? <input type="checkbox"/> No <input type="checkbox"/> Yes (List allergies)	
Name of physician/health care provider:	Phone number of physician/health care provider:	

I give permission for my child _____ to be given the above medication. I give permission for the school nurse or school principal to contact the physician/health care provider named above, or the pharmacist who filled the prescription to discuss the medication and my child’s health. I give permission for the physician/health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child’s health to the school nurse or school administrator. I understand that I am responsible for notifying the school if my child’s medication change in any way. (Each time there is a change in medication, dose or time of administration, a new permission form must be completed.)

 Signature of Parent/Guardian

 Date

 Print Name of Parent/Guardian

 Daytime Phone Number