

575 Washington Street Newton, MA 02458
Health Office: 617-244-1841 x 326 Fax: 617-244-796-9175

MEDICATION PERMISSION FORM

This form is to be completed by **physician** and **parent** before any prescription or over the counter medication can be dispensed (M.G.L. Chapter 112 § 80). Acetaminophen and ibuprofen are exceptions, requiring a separate permission form, which is available at www.trinitycatholic.com

Student name _____ Grade _____ D.O.B. _____ M / F _____

PHYSICIAN Please complete the form if the above named student must take medication during school hours.

Medication _____ **Dosage** _____ **Route** _____

Frequency _____ **Time(s) to be given at school** _____

Date of order _____ Discontinuation date _____

Diagnosis _____ Drug/Food Allergies _____

Special Instructions _____

Possible side effects _____

Name of licensed prescriber _____ Title _____

Signature of licensed prescriber _____

Address _____ Phone _____

Consent for self administration: Has the student been instructed to self administer medication and may he/she do so at school? Yes ___ No ___ (The school nurse will determine safety and appropriateness while at school)

PARENT

Name of Parent/Guardian _____

Drug/Food Allergies _____

Other medications taken at home _____

I, the undersigned parent or guardian, gives permission to the school nurse (or school personnel designated by the school nurse) to administer the above medication to my child or to supervise my child in taking the above medication. I authorize the school nurse to share information about such medication administration, as the school nurse deems necessary for the health and safety of my child. I agree to release, indemnify and hold harmless Trinity Catholic High School and its employees and agents from and against any claim either my child or I may have as a result of any act or omission, which may arise out of this authorization.

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

Telephone numbers where you may be reached: (home) _____

(work) _____ Cell / Pager _____

Please read the medication policy on the back of this form.

POLICY ON MEDICATIONS TO BE GIVEN AT SCHOOL

NON-PRESCRIPTION MEDICATION (OVER-THE-COUNTER REMEDIES FOR COUGH, COLDS, STOMACHACHE ETC.) AS WELL AS PRESCRIPTION MEDICATIONS MUST BE BROUGHT FROM HOME AND BE ACCOMPANIED BY A COMPLETED MEDICATION PERMISSION FORM. ACETAMINOPHEN AND IBUPROFEN ARE SUPPLIED BY THE HEALTH OFFICE AND REQUIRE A SEPARATE PERMISSION FORM, WHICH IS AVAILABLE AT WWW.TRINITYCATHOLIC.COM

The school nurse is responsible for the administration of all medication. She/He may delegate this task to other trained personnel who may administer the medication under the supervision of the nurse.

The following statements highlight the main points of the medication policy. The entire policy is available for review in the Health Room as well as at the Newton Health Department (NHD) office and on the NHD web page (www.ci.newton.ma.us).

- Medication administration should be scheduled at times other than during school hours whenever possible.
- All medication must be delivered by the parent / guardian or designated adult.
- Only a thirty (30) day supply of medication will be accepted at any time.
- All medication must be delivered in a pharmacy or manufacturer labeled container.
- The pharmacy-labeled container can be used in lieu of a physician's order only in the case of short-term medications, i.e. those medications to be given for ten (10) school days or less.
- Self medication can be allowed under certain circumstances after consultation with the school nurse.
- If a medication needs to be given during a FIELD TRIP the school nurse must be contacted in advance to make special arrangements prior to the outing.
- Medication orders must be renewed at the beginning of each school year.

Medication quantities received by the school.

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____

Date: _____ Amount: _____ Received by: _____