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. Teachers, administrator and administrative staff shall not administer medication to students except as provided in these School Medication Procedures.

Procedures

1. Administration. No school personnel shall administer any prescription or non-prescription medicine unless the School has the student's current and complete **Medication Authorization Form** approved and signed by the School Principal.

A **Medication Authorization Form** is distributed for each student at the beginning of each school year or enrollment of a new student during the year. A copy of the **Medication Authorization Form** is attached. **Medication Authorization Forms** are available in the school office.

The School retains the right to deny requests to administer medication to the students provided that such denial is indicated on the **Medication Authorization Form**. If the School denies a request and authorization for the administration of medication, 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 or designee of the parent/guardian administer the medication in school.

2**. Self-Administration**. A student may self-administer medication at school if so ordered by his or her licensed prescriber per the student's current and completed **Medication Authorization Form**. Students who suffer from asthma, allergies, or other conditions 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 School has on file for the student a current and completed **Medication Authorization Form**. Otherwise, such medication must be stored in a locked cabinet under the control of the' School and the self-administration of medication shall be under the supervision of the School.

3**. Appropriate Containers**. It is the responsibility of the parent/guardian to provide the School with all medication in appropriate containers that 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.

4**. 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, hislher 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 School will appropriately discard the medication.

To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

_____ SCHOOL, _____, ILLINOIS

_____	_____	_____	_____
Student 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 this entire form to the School and the 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.

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 (PRINT)	Parent/Guardian (PRINT)
_____	_____
Parent/Guardian (SIGNATURE)	Parent/Guardian (SIGNATURE)
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Home Phone Business Phone	Home Phone Business Phone

To be updated by parent/guardian/physician annually

Physician's Order

Student _____ Grade _____

_____ _____ _____

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

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

(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY**:
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.

(Please circle) YES NO

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 to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

_____ _____

Physician's /Prescriber's Signature Date Signed

_____ _____

Physician's/ Prescriber's Name (PRINT) Emergency telephone number

_____

Address City , State, Zip Code

Medication Authorization <u>approved or denied</u> and signed this ____ day of _____,
(Please circle one)

20 ___, by _____ on behalf of
Signature of Principal

_____School, _____ , Illinois