FALL RIVER PUBLIC SCHOOLS
STUDENT HEALTH OFFICE

Dear Parent/Guardian:

We would like to inform you of the state regulations governing the administration of all medications administered in school. These policies have been put in place to ensure the health and safety of children needing medications during the school day.

It is recommended that medication be administered at home. However, students who must receive medication during the school day are required to comply with these regulations.

These regulations require the following forms must be kept on file in your child's health record before we begin to give **ANY** medications in school.

1. **Signed consent by the parent or legal guardian to give the medication.** Please complete the consent form and return it to your school nurse.

2. **Signed medication order.** The written medication order form should be taken to your child's licensed prescriber (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. All medication orders must be renewed at the beginning of each academic year and as needed. If a physician feels it is necessary for a student to carry an inhaler on his/her person, a specific written order must be obtained from the physician.

Medications should be brought to the school nurse by a parent/guardian or designated responsible adult in a pharmacy or manufacture-labeled container and sealed in the pharmacy bag as dispensed by the pharmacy.

Please ask your pharmacy to provide separate bottles for school and for home.
No more than a **30 day** supply of the medication should be sent to school at one time.

No over-the-counter medications, including Tylenol and ibuprofen, will be given in school without the required signed medication forms.

If you have any questions, please contact the school nurse.
Thank you for your cooperation.

FALL RIVER PUBLIC SCHOOLS
STUDENT HEALTH SERVICES

PARENT/GUARDIAN AUTHORIZATION FOR MEDICATION

Student's Name ______________________________ Date of Birth ___________
Parent/Guardian Name (print) ____
Phone Numbers: Home _________ Work _________ Emergency ___________
Person to be notified in case of medication emergency:

____
Name Relationship Phone

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality)____

____

My son/daughter has the following drug allergies:_______________________

I consent to have the school nurse (school personnel designated by the nurse) administer the medication prescribed by:____
Physician's Name

____

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate: _____Yes _____ No

I give permission for the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I give permission for the school nurse to take a photo identification of my son/daughter.

I understand that while my child attends a field trip the above medication may/may not be required. At the nurse's discretion, I authorize my child's teacher/responsible adult to administer his/her medication as ordered by the physician.

I understand I may retrieve the medication from school at any time, however, the medicine will be destroyed if not picked up within one week following termination of the order or on the day school closes for the summer..

Parent/Guardian Signature ______________________________ Date ___________
NOTE: All medication, including non-prescription, must be kept in the nurse's office.
STUDENTS ARE NOT ALLOWED TO CARRY MEDICINE IN SCHOOL

FALL RIVER PUBLIC SCHOOLS
STUDENT HEALTH SERVICES

MEDICATION ORDER TO BE COMPLETED BY PHYSICIAN

Name of Student ______________________________ Date of Birth ______________

Address ______________________________________ Grade ______________
(street) (city/zip code)

Name of Licensed Prescriber ______________________________________

Business Phone Number ________________ Emergency Phone Number ____________

Medication ____

Route of Administration ________________________ Dosage ______________

Frequency __________________ Time(s) of Administration ________________

(PLEASE NOTE: Whenever possible, medication should be scheduled during home hours)
Specific Directions or Information ______________________________________

Date of Order _________________________ Discontinuation Date ______________

Diagnosis** ____

Other Medical Conditions** ____

Optional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed ____

2. Other medications taken by student ** ________________________________

3. Consent for self administration (provided school nurse determines it is safe and appropriate) ________YES _______NO

____ ____________________
Physician Signature Date

** If not in violation of confidentiality

********* RETURN TO SCHOOL NURSE*********