Dear Parents,

Attached to this letter are copies of the Parent/Guardian Medication Consent Form and a Physician Order for Medication Form. **Please keep these forms in case you need them during the school year**. Additional forms are available in the School Office. Medication will **NOT** be given to your child if we do not have them on file.

Below is the medication policy from the Archdiocese of Milwaukee.
Administration of Medication to Students

1. No medication will be administered by school personnel without the Medication Consent Form and the Physician Order for Medication Administration Form being filled out and returned to the principal/school secretary.
   a. Medication Consent Form must be filled out by the parent/legal guardian and addressed and returned to the individual(s) administrating the medication and/or School Nurse.
   b. Physician Order for Medication Administration Form must be filled out by the prescribing physician and addressed and returned to the principal/school secretary.
   c. The School Office shall maintain an accurate medication file, which includes all of these necessary forms on each student receiving medication.
2. Medication to be given in the school must have the following information printed on the container:
   a. Child's full name
   b. Name of the drug and dosage
   c. Time to be given
   d. Length of time to be administered
   e. Physician's name
3. Medication will be taken by the child at the designated time administered by the Secretary and/or Principal. IT IS THE RESPONSIBILITY OF THE STUDENT, IF APPROPRIATE, NOT SCHOOL PERSONNEL, TO GET HIS/HER MEDICATION AT THE DESIGNATED TIME.

Asthma Inhalers

Schools recognize the importance and necessity of students being allowed to carry asthma inhalers. Students in grades K-12 may self-administer certain emergency prescription medications, such as inhalers and glucagons, while at school only under the supervision of school staff. An elementary student who carries an inhaler on his/her person will need to have an Archdiocese of Milwaukee release form completed and signed by the student's physician, parent/legal guardian, principal, and homeroom teacher. The form states that the student has been instructed in and understands the purpose, appropriate method and frequency of use of his/her inhaler. The school is absolved from any responsibility in safeguarding the student's inhaler. This Form can be obtained from the School Secretary.

4. Only limited quantities of any medicine are to be kept at school.
5. All medication administered at the school will be kept in the school office. NO MEDICATION, AT ALL (INCLUDING COUGH DROPS), IS TO BE KEPT IN THE CHILD'S CLASSROOM, OR ON THE CHILD'S PERSON. Parents sending a one-time dose of aspirin, cough syrup, etc. are to send this to the office along with a note giving permission to administer and instructions for the administration. TEACHERS ARE NOT TO BE ASKED TO ADMINISTER ANY MEDICATION, EXCEPT ON A FIELD TRIP AND THEN ONLY WITH WRITTEN PERMISSION FOR THE TEACHER IN CHARGE, TO ADMINISTER THAT ONE TIME DOSAGE.
6. The length of time for which a drug is administered, which is not to exceed the current year, shall be contained in the written instructions from the prescribing physician. Further written instructions must be received from the physician if the drug is to be discontinued or the dosage time changed from the original written instructions.
7. School personnel should not, UNDER ANY CIRCUMSTANCES, provide any non-prescription medicine to any student without meeting the criteria in 1 - 6 above, including the necessity of having written authorization from the student's physician.
8. An accurate and confidential system of record keeping will be established for each student receiving medication.
9. The principal/secretary may provide aspirin or other non-prescription medicine to students with written authorization from the student's physician and/or parents.

St. Dominic School
18105 West Capitol Drive
Brookfield, WI 53045
414-783-7565

PARENT/GUARDIAN MEDICATION CONSENT FORM

(Please type or print)

Full name of child to be medicated: ____

Name of drug and dosage: ____

Hour(s) medication to be given: ____

Number of days to be taken: ____

Name of physician prescribing medication: ______________________________________

Physician's phone number: ____

Reason for medication: ____

I hereby give permission to the Health Room/Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

____

Signature of Parent/Legal Guardian Date

____

Address

____

Home Phone # Work Phone #

Please return this form completed along with the medication(s) to the school office.

TO BE FILLED OUT BY PHYSICIAN

To: ______________________________________

(Induvidual(s) Administrating Medication)

Please administer the following medication(s) to:

Name of Student __________________________ Address ______________________________________

Telephone Number _________________________ School **St. Dominic** Grade _________

Diagnosis ____

Physician Medication Orders: DAILY MEDICATIONS

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:	
				From: To:	
				From: To:	

PRN MEDICATIONS (as is needed)

Medicine	Route	Dose	Frequency	Duration	Condition under which medication should be given	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:		
				From: To:		
				From: To:		

The information on this form constitute my physician medication orders for the subject student. I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office ________________________________ Address ______________________________

Physician's Signature ________________________________ Phone ______________________________

Date ___________________________