

**POLICY FOR DISPENSING MEDICATIONS
ST. WENDELIN SCHOOLS**

The responsibility of giving medication at school is a serious one, and it is preferred that medication be given at home whenever possible. If it must be given during school hours Ohio School Law requires:

1. Assure that the medication container is the one dispensed by the physician or pharmacist and labeled with:
 - a. The student's name
 - b. The name of the medication
 - c. The amount of the dosage, and route of administration
 - d. The time of administration
2. Assure written request, including instructions as to name of medication, dosage time and possible side effects, **be signed by a parent/guardian and also by the physician** be on file before any medication is given.
3. Be advised that only medicine prescribed by a doctor will be given during school hours.
4. A new request form must be submitted to the school each year and as necessary if there is a change in the medication order. If the doctor changes the dosage size, strength, time, or route of administration a new form must be submitted. Under **NO** circumstances will medication be dispensed without written permission or without a container identifying the student's name, name of medication, and dosage particulars.

VERBAL PERMISSION WILL NOT BE ACCEPTABLE AT ANY TIME.

If there are any questions, please contact St. Wendelin's School Nurse.

Phone: 419-435-1809 Elementary; 419-435-8144 High School

Fax (Elementary) 429-435-7826 Fax (High School) 419-436-4042

Return this portion when all sections are completed. If faxing please print all information legibly.

Student's name _____

Student's home address _____

St. Wendelin Elementary School _____; Junior High _____; (Fill in grade and homeroom (2T)

High School grade _____ (Fill in grade level)

PHYSICIAN'S SECTION

NAME OF MEDICATION _____ DOSAGE _____

ROUTE OF ADMINISTRATION _____

TIME/ INTERVAL MEDICATION IS TO BE ADMINISTERED _____

DATE TO BEGIN MEDICATION _____

DATE MEDICATION IS TO BE DISCONTINUED _____ ALL MEDICATION ORDERS AUTOMATICALLY
OUTDATE THE LAST DAY OF THE SCHOOL YEAR)

POSSIBLE SIDE EFFECTS _____

PHYSICIAN'S SIGNATURE _____ TYPE/ PRINT PHYSICIAN NAME _____

PHYSICIAN'S PHONE NUMBER _____ TODAY'S DATE _____

PARENT / GUARDIAN SECTION

I authorize St. Wendelin School Staff to administer this medication and agree to:

1. Send and maintain an adequate supply of medication at school
2. Notify the school of changes in physician
3. Notify the school if dosage, medication, form, or procedure is changed or discontinued

Parent / guardian signature

date

type or print parent / guardian name

SELF MEDICATION FOR ASTHMA INHALERS

Authorization Form

Student Name _____ Date _____

Address: _____

Grade level and homeroom if applicable: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Adverse reactions that should be reported to the physician: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event that the medication does not produce the expected relief from the student's asthma attack:

Other specific instructions: _____

Physician and parent / guardian names, signatures and emergency phone numbers:

Physician name: _____ Phone # _____

Signature: _____ Date: _____

Parent/ guardian name: _____ Phone (work) _____

Signature: _____ (home) _____

(other) _____

Copies must be provided to the Principal and to the School Nurse if one is assigned to the student's building