EMBED MSPhotoEd.3

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Health Office Procedures

Should your child require medication to be taken during school hours, the following must be done:
A written doctor's order specifically stating child's name, name of medication, dosage and times to be given must be on record.
Written consent of parent for school to administer the medication (Form on Back➔)
Unopened medication properly labeled by the pharmacy brought in by a parent.
Medication may NOT be sent in the child's backpack.

The above procedure will be strictly enforced!

Parents are required to send a written excuse to the teacher when a student is absent for any reason. This is the law.

If your child is unable to participate in gym, a note must be brought to the nurse stating the reason.

A child who does not feel well will be checked and observed by the school nurse. If the condition requires that the child be sent home, the nurse MUST be able to reach a parent to make necessary arrangements. It is imperative that the health office have correct home, business and emergency numbers to contact a responsible person. Please notify us immediately of any changes to contact information.

Please make every effort to schedule Doctor and Dentist appointments after school hours.

Notify the health office if any of the following should occur:
-An injury or illness outside of school
-Any type of immunization is received
-Your child develops an allergy
-Other pertinent information related to your child's health

Thank you for your understanding and cooperation with these procedures. As always, if you have any questions or concerns, please feel free to contact me.

Sincerely,

Laura Riddick, RN
School Nurse

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING SCHOOL

To be completed by the parent or guardian:

I request that my child _____ in grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication:

(Signature of Parent or Guardian)
(Date)

(Address)

(Home Phone) (Cell Phone) (Work Phone)

To be completed by the licensed health care prescriber.

I request that my patient, listed below, receive the following mediation:

Name of Student _____ D.O.B.

Diagnosis:

Name of Medication:

Prescribed Dosage, Frequency and Route of Administration:

Time to be taken during school hours:

Duration of Treatment:

Possible Side Effects & Adverse Reactions (if any):

Other Recommendations:

Name of Licenses Prescriber & Title (Please Print)

(Prescriber's Signature) (Date)

(Address) (Phone Numbers)

St. Peter's Regional School

Changing the World, One Student at a Time