

# ARCHDIOCESE OF ATLANTA

## MEDICATION PERMIT FORM

All medication should be given outside of school hours if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the school office or nurse.
2. All necessary medication prescribed for a student by a doctor or dentist must have this Medication Permit Form signed by the physician and parent. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. "Over the counter" medication must be in original labeled container. Medications sent in baggies or unlabeled containers will not be given.
3. The **parent** is responsible to bring all medication to the clinic/office and to pick up unused medicine or it will be destroyed.
4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements and other nutritional aids not approved as medication by the FDA, will not be administered at school.
5. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the school day, the parent may come to the school office/clinic and administer it.
6. All medications must be kept in a locked cabinet/drawer in the school office/clinic and administered in the school office/clinic.
7. **High School** students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler must also be kept in the clinic for use as needed. If a student allows another person to use the inhaler, the privilege of carrying one's inhaler may be revoked for both parties involved. Only those students in High School may transport their medication from home to the school office/clinic, and return unused medication home.
8. Only the **parent or adult designee** perform nebulizer treatments in school.

TO THE NURSE OR HEALTH REPRESENTATIVE OF: \_\_\_\_\_ SCHOOL

NAME OF STUDENT: \_\_\_\_\_ GRADE: \_\_\_\_\_ ROOM: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE AND DIRECTIONS FOR GIVING: \_\_\_\_\_

BEGINNING DATE: \_\_\_\_\_ ENDING DATE: \_\_\_\_\_

I hereby request that the medication specified above be given to the above named student, and that the medication may be given by someone other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Atlanta, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Atlanta, its agents, servants, or employees, including, but not limited to the parish (if applicable), the school, the principal, and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

(STAMPED SIGNATURE NOT ACCEPTED)

PHYSICIAN'S TELEPHONE NUMBER: \_\_\_\_\_

# St. Joseph Catholic School Medication Permit Form with Checklist and Dosage

Weight \_\_\_\_\_ Name \_\_\_\_\_ Physician Signature \_\_\_\_\_

**CHECK THE ONES THAT YOU WOULD LIKE TO BE AVAILABLE AT SCHOOL AND FILL IN THE DOSAGES WHERE IT APPLIES.**

- \_\_\_\_\_  \_\_\_\_\_ mg Diphenhydramine (**BENADRYL**) q 4-6 hours as needed for allergy symptoms
- \_\_\_\_\_  \_\_\_\_\_ Diphenhydramine HCL 2% and Zinc Acetate 0.1% (**BENADRYL SPRAY**) for topical analgesic and skin protectant
- \_\_\_\_\_  \_\_\_\_\_ **Hydrocortisone** 1% Cream for relief of itching
- \_\_\_\_\_  \_\_\_\_\_ **Polymyxin B Sulfate/Bacitracin Zinc/Neomycin Sulfate** for first aid antibiotic
- \_\_\_\_\_  \_\_\_\_\_ **Benzocaine** 20 % gel for dental pain
- \_\_\_\_\_  \_\_\_\_\_ mg Acetaminophen (**TYLENOL**) q 4-6 hours for pain and/or fever
- \_\_\_\_\_  \_\_\_\_\_ mg Ibuprofen (**MOTRIN**) q 6-8 hours for pain and/or fever
- \_\_\_\_\_  \_\_\_\_\_ mg/tab **Calcium Carbonate/Simethicone** for indigestion, upset stomach, heartburn and bloating or gas
- \_\_\_\_\_  \_\_\_\_\_ mg/tabs Bismuth Subsalicylate (**PEPTO-BISMAL and EQUATE Stomach Relief**) tablets for heartburn, nausea, diarrhea, indigestion, upset stomach
- \_\_\_\_\_  \_\_\_\_\_ mg/tabs **Calcium Carbonate** tablets for heartburn, indigestion, upset stomach
- \_\_\_\_\_  \_\_\_\_\_ mg Pseudoephedrine (**SUDAFED**) for nasal and sinus congestion/pressure
- \_\_\_\_\_  \_\_\_\_\_ any type of **cough drop** with or without menthol for cough, sore throat
- \_\_\_\_\_  \_\_\_\_\_ tsp of Dextromethorphan HBr 10 mg, Guaifenesin 100mg, Phenylephrine HCL 5mg in 5 cc (**TOPCARE** cough formula) for nasal decongestant, cough suppressant, expectorant
- \_\_\_\_\_  \_\_\_\_\_ tsp of Dextromethorphan HBr 5 mg, Guaifenesin 100 mg in 5 cc (**TARGET** mucus relief cough) for expectorant, cough and congestion
- \_\_\_\_\_  \_\_\_\_\_ tsp of Brompheniramine maleate 1 mg, Dextromethorphan HBr 5 mg, Phenylephrine 2.5 mg in 5 cc (**EQUATE Cold and Cough and DIMETAPP**) for nasal decongestant, antihistamine, cough suppressant
- \_\_\_\_\_  \_\_\_\_\_ tsp of Guaifenesin 50 mg and Phenylephrine 2.5 mg in 5cc ( **TRIAMINIC Chest**) for chest congestion and stuffy nose
- \_\_\_\_\_  \_\_\_\_\_ tsp of Dextromethorphan HBr 5 mg and Phenylephrine 2.5 mg (**TRIAMINIC Day Time Cold and Cough**) for stuffy nose and cough

All capitalized words are examples of trade names for these medications. This list does not specify all the trade names associated with each product. Please feel free to add any over the counter medication that you would like your child to receive. **Attach this form to the Medication Permit Form which has been signed by a physician.** Please try to follow the above format when adding medication.