NORTHEAST SCHOOL CORPORATION

620 N Washington St.

Shelburn, In 47879

PHONE 812/383-5761

Letter to Parents Regarding Students Taking Medications at School

Dear Parents,

As a school corporation, we understand that in order to be safe and able to benefit from the educational program, some students will need to take medicine at school. If your child must have medication of any type given during school hours, including over the counter drugs, you have the following choices: 1.) You may come to school and give the medication to your child at the appropriate time(s), 2.) you may discuss with your healthcare provider an alternative schedule for administering medication outside of school hours, or 3.) you may *complete* the *attached form* and have it signed by the healthcare provider.

School personnel will not administer any medication to students unless they have received written instructions from the healthcare provider or the parent and the medication has been received in the appropriately labeled container. This means a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container and will be administered according to the written instructions.

Parents are responsible for transporting prescription medications to and from school. If this is a hardship that cannot be resolved easily, School Bus Drivers may transport medication to and from the school. High School students may transport their own medication if parents give permission for them to do so.

If you have any questions about our medication policy, or any other issues related to the administration of medication in the schools, please contact the school nurse by calling the Central Office at 383-5761.

Thank you for your cooperation,
Abby Mason, RN

School Corporation Nurse

PERMISSION FORM FOR PRESCRIBED MEDICATION

Student:_____ Date of Birth_____
School:_____ Grade:_____ Teacher:_____

To be completed by the physician or authorized prescriber

Reason for Medication:_____
Name of Medication:_____
Form of Medication/Treatment:
___Tablet/Capsule ___Liquid ___Inhaler ___Injection ___Other

Instructions (Schedule and dose to be given at school):_____
_____
Start date:_____ Stop date:_____
___For episodic/emergency events only

Restrictions and/or important side effects:
___None anticipated
Please describe:_____
_____

Special storage requirements:
___None ___Refrigerate ___Other:_____

This student is both capable and responsible for self-administering this medication:
___No ___Yes-supervised ___Yes-unsupervised
This student may carry this medication: ___No ___Yes

Date:_____ Signature:_____

To be completed by parent/guardian

I give permission for _____ to receive the above medication at school according to school policy.

_____ _____ _____
(Date) (Signature) (Relationship)