LAKEWOOD PUBLIC SCHOOLS

MEDICATION POLICY

Dear Parent/Guardian:

The administration of medication by the School Nurse is discouraged as it is not normally a function of education. Some children with chronic illnesses and specific disabilities, however, often require medication during the course of the day. If your physician decides it is necessary for your child to receive medication during the school day, it is our district policy that the following steps be taken:

1. **Written orders** are to be provided to the school from the private physician indicating the diagnosis or type of illness, the name of the drug, dosage and time of administration.

2. The parent/guardian must provide a **written request** for the administration of the medication at school.

3. The medication must be brought to school in the **original container,** appropriately labeled by the pharmacy or physician. The medication should be brought in by the parent/guardian.

This Medication Policy includes over-the-counter medications, as well as prescription drugs. **Students are prohibited from carrying any medications on their person unless requested in writing from their private physician.**

Thank you for your cooperation.

Sincerely,

Your School Nurse

LAKEWOOD PUBLIC SCHOOLS

MEDICATION PERMISSION

School Year_____
Grade_____
ID#_____

Dear Parent/Guardian:

We attempt to discourage administration of medication in the schools. However, if your health care provider decides it is necessary for your child to receive a medication during the school day, his/her approval and specific directions must be provided to the school

Medication must be given to the nurse in the original prescription bottle by the parent/guardian.

Name of Student_____

Address_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of order_____ Name of drug_____

Dose to be given_____

Time and circumstance of administration at school_____

_____

Can a reaction be expected? _____Yes _____No

If yes, please describe_____

_____

Have the potential side effects been explained to the parents by the health care provider? _____
_____Yes _____No

Health Care Provider Stamp _____ _____
Signature Date

_____

I, the parent/guardian of _____ (student's name) am aware of the possible side effects of the medication prescribed by my health care provider.

I hereby give permission for the School Nurse to administer the medication to my child during school hours.

Parent/Guardian Signature_____ Date_____