St. Michael-St. Gabriel the Archangel Catholic Elementary School

PARENT/GUARDIAN RELEASE
SELF-ADMINISTRATION OF MEDICATION

Archdiocese of Indianapolis Policy Statement 2008-02 recognizes that parents (guardians) have the primary responsibility for the health of their children. Although it is strongly recommended that medication be administered in the home, the health of some children and youth may require that they receive medication or other medical care while in the care of (*name of school or program*).

If a (*child/youth/student*) must take medicine while at (*school, parish or archdiocesan program*) please be advised of the following:

- ✓ Parents (guardians) should confer with their medical practitioner to arrange medication intervals to avoid administration of medication outside the home whenever possible.
- ✓ When medication absolutely must be taken at other times outside the home, parents (guardians) shall provide explicit written instructions including, in some cases, instructions as necessary from a medical practitioner regarding the need for medication or specific medical care.
- ✓ Parents (guardians) signing this form are, in most cases, providing written permission for **non-medically trained personnel** to oversee the **self-administration** of medication or necessary routine medical care **by the (*child, youth, student*)** depending upon age and capability.
- ✓ Medical circumstances requiring the direct measuring and/or administration of medications, injections, blood tests, observation of symptoms, specific emergency responses by non-medically trained staff personnel or the possession and use of inhalers or other medical devices, shall be handled on a case-by-case basis according to a specific Individual Health Plan developed and signed by a physician or other health care professional and kept on file for the (*child/youth/student*).
- ✓ (*Children/Youth/Students*) are not permitted to carry medications (including analgesics, herbs, enzymes, oils, etc.) on their persons, except for inhalers and other medical devices with specific permission. Medications will be secured in (*the office, with the director, trip leader*).
- ✓ All medication is to be delivered and taken home by the parent (guardian) at the end of the medical regimen or (*school year/program/event, trip*) (*Change: High school age youth may deliver and take home medicine with advance parent [guardian] permission*).
- ✓ All medication is to be taken in the presence of a designated staff member and documented in a confidential log.
- ✓ **No medication** of any kind is to be provided by the (*school, parish, archdiocesan program*), staff or volunteer personnel.
- ✓ Prescription medication must be in the original pharmaceutically dispensed and labeled container. The prescription label will be considered the written order of the medical practitioner in most cases.
- ✓ Non-prescription medication must be in the original container in which it was purchased. Please provide medicine cups/spoons as necessary for liquid medication.
- ✓ Parents must fill out, sign and date a new form for each medication or to change medication instructions (*and/or for each event/trip*).
- ✓ All medication releases must be renewed at the beginning of each (*school/program*) year (*or for each trip/event*).

Please provide specific written instructions below for administration of medication during (*school, program hours, event/trip*):

Name of (*child/youth/student*): (*may add other necessary ID information*)	
Name of medication: ☐ Prescription ☐ Non-Prescription ☐ Refrigeration Required	
Diagnosis/reason the medication is to be taken:	
The appropriate dose, method of administration (i.e., by mouth) and specific instructions (i.e., take with food, etc.):	
The time or times of day (hours) medication should be taken in our care:	
The start date and number of days/weeks/ months the medication is to be taken:	
Any known side-effects of the medicine and/or symptoms of the condition being treated and known tolerance to medicine:	

I hereby give permission for non-medical staff personnel to oversee self-administration of the medication specified above by my child:

Parent (Guardian) Signature: _____ Date: _____ Emergency Phone Numbers: _____ _____

Has your child had:	Yes	No
Vision Screening		
Does your child wear glasses?		
Hearing Screening		
Does your child wear hearing aids?		
Speech Screening		
Has your child ever received services?		
Language Evaluation		
Has your child ever received services?		
Psychological Educational Testing?		
ADD/ADHD Testing?		
Occupational Therapy?		
Physical Therapy?		
Counseling?		
Referral for any of the above services?		
Does your child have a specific health condition, such as:		
Allergies (Please specify.)		
Asthma		
Convulsions or Seizures		
Diabetes		
Ear and/or Throat Problems		
Heart		