Dear Parent/Guardian,

St. Vincent de Paul School will be following the St. Louis Archdiocese Medication policy guidelines listed below and in the Family Handbook.

Ideally, all medication should be given at home. Most physicians are aware of the problems associated with giving medication in schools. They may be able to change time schedules so medication can be given before and after school hours. If a medication (prescription or over-the-counter) must be given at school, the parents must follow these requirements:

1. An emergency authorization form must be on file in the school listing the name of child's physician and phone numbers. (Note: SVS parents usually complete this in the beginning of the school year.)

2. There must be a written physician's order for the medication with the name of the student, name of the medication, dosage, time interval to be given (if ordered "as needed" – a plan must be provided), and diagnosis or reason for the medication. A current prescription label on container may serve as a physician's order.

3. Written permission must be provided by the parent/guardian requesting that the school comply with the physician's order. (Note: SVS has over-the-counter and prescription medication forms to complete #2 & #3 requirements – see attached.)

4. Prescription medication should be brought to school in a container appropriately labeled by the pharmacy. Non-prescription medication should be in the original container. Ideally, the parent will have two containers, one for home and one for school. For medications that will be given for the entire school year, the child needs a new prescription container each school year.

5. If there is ANY change in the dose or timing of the medication, the physician must submit the change in writing. This may be faxed or mailed to the school. **A parent may not give permission to administer medication differently than the physician's order.**

6. The school has the right to call the physician to clarify a medication order.

7. The medication, forms, and notes are to be brought to the school office.

8. Students will not be able to carry medications with them at school.

If your child requires Tylenol for headaches or tooth pain, cough syrup for a cough, Advil for abdominal cramping, etc., you will need a physician's order. You may want to contact your physician and have him/her mail or fax (SVS Fax 636-433-2924) the order to school. Having the order in place will save your child from needing the medication and not being able to get it. The over-the-counter medications must be supplied by the parent in their original container.

Dear Parents/Guardians,

Due to State regulations, we will be unable to administer over-the-counter medicine to your student without a doctor's order. School does not supply any over-the-counter medication. All medications must be sent from home in their original container and marked with the student's name.

Some examples of over-the-counter medicine are:

* Pain relievers (Tylenol, Advil, aspirin or generic brands)
* Cough or cold medicine (Robitussion or generic brand)

Some examples that do not need a doctor's order:

* Cough drops
* Antibiotic cream (Neosporin or generic brand)
* Hydrocortisone 1% Anti-itch cream (Cortaid or generic brand)
* Antacid Tablets (Tums or generic brand)
* Chap-Stick or generic brand

If you feel that your child/children may require over-the-counter medicine during this school year, please have your physician fill out the form below and return it to school.

****

Parental Consent for OVER-THE-COUNTER MEDICATION Administration to their Child

Date: _____ School: __St. Vincent de Paul School_____

Student: _____ Grade: _____

My child is to receive _____ medication according to the physician's directions. I give my permission for this over-the-counter medication to be administered to my child during the school year. The school has my permission to call the physician with any questions regarding the medication. My child has _____ drug allergies.

Signature: _____ Relationship to student: _____

Physician Consent for OVER-THE-COUNTER MEDICATION Administration

Name of Student: _____

Medication: _____ Dose: _____

Time Interval: _____

Reason for treatment: (Please check appropriate line(s).)

_____ Pain

_____ Cough

_____ Headache

_____ Temperature above _____F

_____ Upset Stomach

_____ Orthodontic pain

_____ Other: _____

Restrictions and/or Side Effects: _____

Physician Signature: _____ Date: _____

All authorizations expire at the end of the school year.

**** Please refer to Dispensing of Medication policy in the St. Vincent School Family Handbook.**

Parental Consent for PRESCRIPTION Medication Administration to their Child

Date: _____ School: __St. Vincent de Paul School_____

Student: _____ Grade: _____

My child is to receive _____ medication according to the physician's directions. This treatment will last _____. I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication. My child has _____ drug allergies.

Signature: _____ Relationship to student: _____

Physician Consent for PRESCRIPTION Medication Administration

(A copy of the doctor's prescription or the pharmacy label may serve as physician consent.)

Name of Student: _____

Medication: _____

Dosage: _____

Time Interval: _____

Diagnosis or reason for treatment: _____

_____

Side Effects to look for: _____

_____

Restrictions: _____

Physician Signature: _____ Date: _____

All authorizations expire at the end of the school year.

**** Please refer to Dispensing of Medication policy in the St. Vincent School Family Handbook.**