



### **Information for Parents of Students that take Prescribed Medications at School**

The Guerin Catholic Medication Policy is available online in the handbook. It is summarized below. Please remember, students are not allowed to carry or transport medication. Parents can begin to drop off school year medications in August (please check the GC updates for specific times). Medications can only be accepted by the nurse. Please do not attempt to leave any medications with the front office staff.

All students taking daily medications are required to have the following forms in the health office

- ☐ **Guerin Catholic High School Medication Order Form** *(filled out by the prescriber)*
- ☐ **Medication Treatment/ Authorization Form** *(filled out by parent/ guardian)*

1. The following medication container requirements must be met

☐ Medication should be in the original pharmacy container with the pharmacy label. Student name, medication name, dosage, and instructions should be current and legible. If you are splitting medication between home and school, please know, most pharmacies will provide an extra labeled container upon request.

2. Any dosage changes during the year must have a doctor's written order.
3. Your student's medication will follow them on field trips and retreats.
4. Many students that take medication at school are also taking daily morning medications at home. Please be aware, you may keep a few doses of your student's morning medications in the clinic. If you opt to do this, we will administer "forgotten" only with parental permission. To do this, we need the same forms as listed above.

Please reach out with any questions or concerns. Thank you!

**The Franciscan Health School Nurses at Guerin Catholic**

(317) 582-0120 Ext.111 FAX 317-219-0615

[nurse@guerincatholic.org](mailto:nurse@guerincatholic.org)



## Franciscan Health/ Guerin Catholic High School Medication Order Form

The prescriber must complete this form fully in order for the school nurse to administer the medication. A new medication order form must be filled out each time there is a change in dosage or time of administration of medication. Alternatively we can accept a written order directly from the providers office via fax at 317-219-0615. All pertinent information must be included.

- Today's Date \_\_\_\_\_
- Name of Student \_\_\_\_\_
- D.O.B \_\_\_\_\_
- Medication Name \_\_\_\_\_
- Dose \_\_\_\_\_
- Frequency (if PRN see below): \_\_\_\_\_
- Time to be given \_\_\_\_\_
- Special Instructions\*\* \_\_\_\_\_

*\*special instructions may include: administer only if the parent notifies RN of a missed AM dose, student should not drive after receiving this medication etc.*

- If the frequency is PRN, for what symptoms should the medication be given?

\_\_\_\_\_

- Condition for which medication is being administered \_\_\_\_\_

\*Prescribers Name: \_\_\_\_\_

\*Telephone number: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*Prescriber's signature \_\_\_\_\_

### Franciscan Health School Nurses

#### Guerin Catholic High School

15300 N. Gray Road Noblesville, IN 46062

(317) 582-0120 Ext.111

FAX 317-219-0615



## Medication/Treatment Authorization (completed by parent/guardian)

| Student First Name | Last Name | Date of Birth |
|--------------------|-----------|---------------|
|                    |           |               |

| Name of Medication/Treatment | Strength/Dose (preferred in mg dosage, i.e. NOT "one pill") | Route (by mouth, inhaled etc) | Frequency (daily, as needed etc) |
|------------------------------|-------------------------------------------------------------|-------------------------------|----------------------------------|
|                              |                                                             |                               |                                  |

**Time of Administration** (specific time or before lunch/after lunch, as needed etc): \_\_\_\_\_

**Reason for which medication is administered:** \_\_\_\_\_

**If medication is to be administered as needed (PRN) for what symptoms should it be given:** \_\_\_\_\_

**Comments/Special Instructions:** \_\_\_\_\_

By signing below, I request that a school nurse (or designee) administer the medication or treatment to the student named above. I understand students may not transport medication to or from school and I assume responsibility for delivery of this medication to and from the clinic. All medications must be in their original container with legible labels. Medications left at school after the end of the school year will be discarded. I will immediately notify the school health professional of any changes to the medication or treatment indicated above. Permission is valid from the time medication and appropriate paperwork are received through the end of the current school year (unless the parent/guardian notifies the school nurse of discontinuation in writing). The school nurse (and designee) may reserve the right to withhold medication pending additional clarification based on clinical judgment. A parent/guardian will be notified immediately in this instance. Medication will only be administered to the student for whom it is prescribed/ requested. I understand I am authorizing this medication to be given on school days during school hours, and on field trips and retreats that occur on school days within school hours.

**Parent/Guardian Name (Printed)** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

|                                                                                                                                                                                   |                    |                      |           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------|-----------|
| Date Received: _____                                                                                                                                                              | Received by: _____ | Quantity Count _____ | Bin _____ |
| <i>I acknowledge this medication has been given to the Guerin Catholic School Nurse at this date and with the quantity above: Signature of parent/guardian: _____ Date: _____</i> |                    |                      |           |

| Med Refill Date | Quantity | Parent Signature | RN Signature |
|-----------------|----------|------------------|--------------|
|                 |          |                  |              |
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|                                                                                                                 |                    |                    |                |
|-----------------------------------------------------------------------------------------------------------------|--------------------|--------------------|----------------|
| Date Returned: _____                                                                                            | Returned to: _____ | Released by: _____ | Quantity _____ |
| <i>I acknowledge that this medication has been returned ***Attach written consent if sent home with student</i> |                    |                    |                |
| Signature of parent/guardian/other _____                                                                        |                    | Date: _____        |                |