Immaculate Conception School

1208 East McCarty Street
Jefferson City, Missouri 65101
Phone: 573-636-7680
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Permission for School Administration of Medication

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school.
Prescription medications to be given at school **should be accompanied by this form, a physician prescription, and provided to the school in the original labeled container** provided by the pharmacist who filled the prescription.
Nonprescription (over the counter) medications **should also be accompanied by this form, and provided to the school in the original labeled container.** It is suggested that all medications administered to your child be approved by his/her doctor.
A separate form is required for each medication and for each child.
NOTE: The school does not maintain a supply of any medications.
(*"Sample" medications* must be provided in a container that appropriately identified the medication and must be accompanied by a note signed by the prescribing physician that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.)

<table>
<tr><td>Student's Name:</td><td>Grade:</td><td>Date of Birth:</td></tr>
<tr><td>Medication:</td><td colspan="2">Dosage (Amount):</td></tr>
<tr><td>Purpose of medication:</td><td colspan="2">Route:
☐ Oral ☐ Other _____</td></tr>
<tr><td>Time of day medication is to be given at school:</td><td colspan="2">Is medication only to be given as needed?
☐ Yes ☐ No</td></tr>
<tr><td rowspan="2">Anticipated number of days medication will be given at school:
☐ until end of current school year
☐ _____ days
☐ _____ weeks</td><td colspan="2">Note any special storage requirements for medication
☐ None ☐ Refrigerate ☐ Other (specify)</td></tr>
<tr><td colspan="2">Is student allergic to any foods, medicines or other items?
☐ No ☐ Yes (List allergies)</td></tr>
<tr><td>Name of physician/health care provider:</td><td colspan="2">Phone number of physician/health care provider:</td></tr>
</table>

I give permission for my child _____ to be given the above medication. I give permission for the school nurse or school principal to contact the physician/health care provider named above, or the pharmacist who filled the prescription to discuss the medication and my child's health. I give permission for the physician/health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that I am responsible for notifying the school if my child's medication change in any way. (Each time there is a change in medication, dose or time of administration, a new permission form must be completed.)

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name of Parent/Guardian Daytime Phone Number

The mission of Immaculate Conception School is to provide instruction in a safe and welcoming environment where children learn Catholic based education and are encouraged to grow with their families in their responsibility as members of the Church and the community.