The Catholic Diocese of Wichita
GUIDELINE 317-T FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

This policy applies to all prescription and over-the-counter drugs, natural and homeopathic remedies and food supplements.

A written note signed by a doctor or dentist requesting that the medication be given during school hours must accompany all medications and include the following: name of student, name of medication, dose amount and time to be given, and the anticipated number of days the medication will be taken at school.

A written request for the medication to be given at school, signed by the parent, must accompany all medication.

The medication must come in an official prescription container or the original over-the-counter packaging. It is the parent's responsibility to supply the medication and assure that it is the same as identified on the label.

Parents must certify that the student has received at least one dose of the medication and has not had an adverse reaction to it.

Any changes in the type of drug, dosage or time of administration must be accompanied by new parent and physician permission signatures and new or newly labeled containers.

Annual renewal is required.

FORM 317-T
REQUEST FOR MEDICATION TO BE ADMINISTERED DURING SCHOOL ATTENDANCE

Name of student _____ Date of Birth _____

Medication _____ Dose _____

Time of day to be given_____ Reason for medication _____

Anticipated number of days to be administered _____

May self-carry inhaler or EpiPen ☐ Yes ☐ No

_____ _____ _____

date ***signature of doctor or dentist, PA or ARNP*** ***name printed***

//

I hereby give permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that school employees who administer any drug to my student in accordance with written instructions from the physician, dentist, physician's assistant, or advanced registered nurse practitioner shall not be liable for damages as the result of an adverse drug reaction suffered by the student because of the administration of such drug. I certify that the child named above has received at least one dose of the medication requested above and has not had an adverse reaction to it.

_____ _____

date ***signature of parent or guardian***