Charlottesville Catholic School
Christ Community Scholars

Medication Administration Policy

The purpose of medication administration during a school day is to provide those medications **essential** and necessary for a student to attend school and benefit from the educational program. Medications must be administered under the safest possible conditions. Whenever possible, it is recommended that medications be given at home.

Per Diocesan Policy, should your child require medication throughout the school day an *Authorization/Parental Consent for Administering Medication* form must be completed by the licensed provider and parent/guardian, and turned into the school nurse. This form is MANDATORY for both prescription and/or over-the counter(OTC) medications. OTC medication will not be dispensed without a licensed professional's permission. For all medications you must include the following:

- Name of child
- Reason for medication
- Name of medication to be administered
- Dosage for medication
- Prescribed quantity for each medication
- Time of administration
- Frequency of administration
- Route of administration

All medication must be brought to school by the parent in the original labeled container prepared by the pharmacy, doctor, or pharmaceutical company (i.e., no envelopes, foil, or baggies). The label should include the following:

- Name of child
- Dosage for medication to be given
- Frequency of administration
- Time of administration
- Route of administration
- Date of prescription
- Expiration date

****NOTE: Specific instructions are necessary (for example, every 4 hours, as needed for headache)****

If your child self carries medication such as an EpiPen/Auvi-Q or inhaler they will need to have a self-carry order signed by parents/guardians and a physician. This order needs to be on the student at all times and a copy in the nurse's office. It is strongly recommended that an additional rescue medication is kept in the nurse's office. Students must meet with the nurse at the beginning of the school year to show compliance, please email Nurse Q to set up an appointment. If you are unable to access these forms please email the nurse at *s.queheillalt@cvillecatholic.org*

If your child has Asthma, Allergies, Seizures, or Diabetes, an action plan must be completed regarding these illnesses. The student will need to have a copy of this plan with them at all times. The nurse must have a copy as well. ***All Action/Medication/Self-Carry forms must be completed and provided to the school no later than the first day of school.***

July 2022

CHARLOTTESVILLE CATHOLIC SCHOOL

Physician Authorization for Medication in School

(for both prescription and over-the-counter medications)

This form may be returned by EMAIL or FAX (434) 964-1373

Student's Name: _____ Grade: _____

Allergies: _____ Birthdate: _____

MEDICATION AUTHORIZATION

(By Healthcare Professional Only)

Relevant Diagnosis: _____

Medication: _____

Dates medication must be administered at school: ___ Short Term (List dates) _____

___Every day at school ___ Episodic/Emergency Events ONLY

Dosage: _____ Route: _____ Time(s) of School Day: _____

Adverse side effects from this medication may occur: ___ YES ___ NO

If yes, describe _____

Action/ Treatment for reactions: _____

FOR ASTHMATIC or DIABETIC STUDENTS ONLY:

This student is both capable and responsible for self-administering this medication:

___ NO ___ YES – Supervised ___ YES- Unsupervised

Student may carry this medication: ___ NO ___ YES

Printed Name: _____

Telephone Number: _____

Physician Signature: _____ Date: _____

(required to self carry)

PARENTAL CONSENT

I am the parent or guardian of _____. I give my permission for him/her to take the above prescribed medication while in Charlottesville Catholic School. I hereby acknowledge that I have read and understood the medication guidelines stated in the School Handbook. I hereby release Charlottesville Catholic School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize the school nurse to contact the licensed prescriber to discuss any concerns regarding this medication.

_____ _____ _____

Parent /Guardian Signature Daytime Phone(s) Date