St. Francis Xavier School
145 N. Waiola Avenue
La Grange, IL 60525

Dear Parent,

This packet of information is the “School Medication Procedures” from the Archdiocesan Office of Catholic Education. Please read the policy and procedures very carefully, noting that if your child is ever in need of self-administration of medication during the school day, it is mandatory that you and your child’s doctor complete the attached forms. Examples of self-administered medications are asthma inhalers or doctor directed medications, which the child must take during school hours.

The Medication Authorization, Parent/Guardian Permission and Authorization, and Physician Request for Self-Administration of Medication forms may be duplicated if you have more than one child requiring these forms and you wish to have them completed over the summer. New forms must be on file at the school each year. Additional forms are also available online at the school website or in the main school office.

The policies for Dispensing Medication are also stated in the Parent-Student Handbook. Thank you for your attention to this important information and the completion of these forms.

Sincerely,

Jimmy Bajner
Principal
Saint Francis Xavier School
(708) 352-2175

SCHOOL MEDICATION PROCEDURES

Parents/guardians have the primary responsibility for the administration of medication to their children. The administration of medication to students during regular school hours and during school related activities is discouraged unless necessary for the critical health and well being of the student. Teachers, administrator and administrative staff shall not administer medication to students except as provided in these School Medication Procedures.

Procedures

1. Administration. No school personnel shall administer any prescription or non-prescription medicine unless the School has the student's current and complete **Medication Authorization Form** approved and signed by the School Principal. A **Medication Authorization Form** is distributed for each student at the beginning of each school year or enrollment of a new student during the year. A copy of the **Medication Authorization Form** is attached. **Medication Authorization Forms** are available in the school office. The School retains the right to deny requests to administer medication to the students provided that such denial is indicated on the **Medication Authorization Form**. If the School denies a request and authorization for the administration of medication, parents/guardians must make other arrangements for the administration of medication to students, such as arranging for medication to be administered before or after school or having the parent/guardian or designee administer the medication in school.

2. Self-Administration. A student may self-administer medication at school if so ordered by his or her licensed prescriber per the student's current and completed Medication Authorization Form. Students who suffer from asthma, allergies or other conditions that require the immediate use of medication shall be permitted to carry such medication and to self-administer such medication without supervision by school personnel only if the School has on file for the student a current and completed **Medication Authorization Form.** Otherwise, such medication must be stored in a locked cabinet under the control of the School and the self-administration of medication shall be under the supervision of the School.

3. Appropriate Containers. It is the responsibility of the parent/guardian to provide the School with all medication in appropriate containers that are:
a. Prescription-labeled by a pharmacy or licensed prescriber (displaying Rx number, student name, medication, dosage, direction for administration, date and refill schedule, pharmacy label, and name/initials of pharmacist) or
b. Manufacturer-labeled for non-prescription over-the-counter medication.

4. Storage of Medication. Medication received by the School in accordance with a completed Medication Authorization Form and in an appropriate container shall be stored in a locked cabinet. Access to the locked cabinet shall be limited to the School Principal, his/her designees, and the school nurse (if applicable). Medication requiring refrigeration shall be stored in a refrigerator that cannot be accessed by students and shall be kept separate from food items. At the end of the school year, or the end of the treatment regime, the student's parent/ guardian will be responsible for removing any unused medication from the school. If the parent/guardian does not pick up the medication by the end of the school year, the School will appropriately discard the medication.

To be updated by parent/guardian/physician annually
Archdiocese of Chicago
Office of Catholic Schools
June 2008

MEDICATION AUTHORIZATION FORM

ST. FRANCIS XAVIER SCHOOL, 145 North Waiola Avenue, LaGrange, IL 60525

Student Name (Last, First, Middle)	Date of Birth	Grade	Date
_____	_____	_____	_____

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the Medication in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (nonprescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Reverse side}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices. I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below. I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

_____ Parent/Guardian (PRINT)	_____ Parent/Guardian (PRINT)
_____ Parent/Guardian (SIGNATURE)	_____ Parent/Guardian (SIGNATURE)
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Home Phone Business Phone	_____ Home Phone Business Phone

To be updated by parent/guardian/physician annually

Archdiocese of Chicago
Office of Catholic Schools
June 2008

Physician's Order

Student _____ Grade _____

_____ _____ _____
Medication/ Health Care Treatment Dosage Time(s) to be administered

_____ _____
Intended effect of this medication /expected side effects, if any

_____

Other medications the student is taking

1**) May student self-administer medication under supervision of school personnel who do not have medical training?**
(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY**:
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.
(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.
(Please circle) YES NO

Administration Instructions:

_____ _____
Physician's /Prescriber's Signature Date Signed

_____ _____
Physician's/ Prescriber's Name (PRINT) Emergency telephone number

_____
Address City, State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____, 20____, by

_____ on behalf of St. Francis Xavier School, LaGrange, Illinois
Signature of Principal