Dear School Parents:

I am writing to you in response to directives from the Office of Lifelong Formation and Education regarding the administration of medication to our students. All medication should be sent to school in its original container with directions for dispensing the medication. All medication must be stored in the school office for dispensing with the exception of inhalers. **A signed "Authorization to Give Medication" form from the parent is required for any medication a student must take, including an inhaler kept in the student's possession.**

> **Prescription medication** will be accepted on an individual basis and administered only as prescribed on the physician's or dentist's authorization. The medicine must be in the original prescription or refill bottle received from the pharmacy.
>
> **Non-prescription (over-the–counter) medication** may be accepted on an individual basis, when provided by the parent or legal guardian, provided a completed authorization to give medication form is on file. ***The medication you provide must be in the original container with the child's name and dosage written on the container.***
>
> **Parents of students requiring prescription or non-prescription medication must complete the Medicine Permission form. The needed form may be found on the website.** If your child should need medication on a one-time, limited or routine basis during the school year you must provide a completed form to the school office. Medication will not be administrated without a completed form on file. ***The school office will accept the completed forms along with medication starting on the day of open house***.

Questions regarding this form may be directed to the school office and / or the Office of Lifelong Formation and Education.

Thank you for your cooperation in this matter.

Sincerely,

Mrs. Wendy Sims
Principal

7813 Shelbyville Road • Louisville, KY 40222 • 502.426.2635 • Fax 502.426.1304 • Stmm.org

Administration of Medication Permission Form For Prescribed / Over Counter Medication

Date received: ______________________

Student: ________________________________ Age: ____________________________

Grade: ____________________ Teacher: ____

To be completed by the physician or authorized prescriber.

Reason for medication: ____

Name of medicine: ____

Form of medication / treatment:

☐ Tablet/ capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other ________________

Instructions (Schedule and dose to be given at school): ________________________________

____

Start: ☐ date form received Other date: ____________________________________

Stop: ☐ end of school Other date / duration: ______________________________

☐ for episodic / emergency events only

Restrictions and /or important effects: ☐ None anticipated ☐ Yes.

Please describe: ____

____

Special Storage Requirements: ☐ None ☐ Yes ___________________________________

Additional Instructions: ____

____

Date: ______________________ Signature: ____

Physician's Name: ____

Address: ____

Phone #: ____

Doctor's Signature: ____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (name of child) ______________________ to receive the above medication at school according to standard school policy. (**School requires parent/guardian to bring the medication in its original container.)**

Date: ________ Signature: ______________________ Relationship: ____________________

Parent/Guardian Phone Numbers: Home ______________ Work ________ Cell ________