

**Rockland Public Schools
Health Services
Rockland, Massachusetts**

Dear Parent/Guardian:

We would like to inform you of the policies that have been put in place to ensure the health and safety of children needing medication during the school day.

Our school district requires that the following forms must be on file in your child's health record before we begin to give any medication at school:

1. Signed authorization for prescription medication form to be filled out and signed by parent/guardian and licensed prescriber.

Medication must be delivered to the school nurse in a current pharmacy or manufactured labeled container by a parent/guardian.

Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty-day supply of medication should be delivered to the school.

In extenuating circumstances, the medication may be delivered to the school nurse by a designated adult providing the parent/guardian notifies the nurse of this arrangement and quantity of the medication being delivered. Please ask your pharmacy to provide separate bottles for nurse and home. All medication delivered will be counted and signed by nurse and parent/guardian.

When your child needs medication to be given during the school day, please act quickly to follow these policies so we may begin the medication as soon as possible. Thank you for your cooperation.

Sincerely,
School Nurse

Rockland Public Schools

Daily/As Needed Medication Administration Form

In order to administer a daily medication to your child, this information must be completed and signed by the appropriate personnel and returned to the school nurse.

Student Name _____ DOB _____ Grade _____

Parent's Name _____

Home Phone# _____ Work# _____ Cell# _____

Name of Prescriber _____ Telephone# _____

In case of emergency and parents cannot be reached call _____

Home Phone# _____ Work# _____ Cell# _____

Diagnosis _____

Food-Drug allergies (state reaction): _____

Medication to be taken _____

Dose _____ Frequency _____ Time _____ Location _____

Date Ordered _____ Duration _____

Specific directions (ie w/food, on empty stomach) _____

All medication must be stored in a prescription bottle labeled by the pharmacy.

Permission:

I consent to have the school nurse or school personnel designated by the school nurse administer the above medication. I give permission for the school nurse to share information relevant to the prescribed medication as she determines appropriate for my child's health and safety.

Medication should be sent and administered on field trips: Yes No

Parents/Guardian signature _____ Date _____

Physicians signature _____ Date _____

School Nurse _____ Date _____