UTSC MEDICATION POLICY

In an effort to ensure student health and safety it is necessary to remind parents of the Union Township Schools Medication Policy.

PRESCRIPTION MEDICATION may only be given to students provided the following is on file at the school:

1) Written permission and authorization signed by the student's parent or guardian stating the student's name, medication, dosage, when it is to be administered, and reason for giving the medication.

2) Written instructions from the student's physician, or typed instructions on the prescription bottle.

NONPRESCRIPTION MEDICATION will be administered at school provided:

1) Medication is sent to school in the original container.

2) Written permission signed by the student's parent or guardians stating the student's name, medication, dosage (provided the request does not exceed the manufacturer's recommendations), and reason for giving the medication.

All medication must be dispensed from the Health Office. Students must not carry any medication in purses, backpacks, pockets, lockers, etc.

Those students with asthma may carry their own inhalers with written authorization from Parent/Physician that includes: Name of student, medication, dosage, time, the intent for student to carry the medication, and ability of student to self-medicate.

Medication equipment and drug supplies will be accepted by the school nurse only from a parent or guardian.

UNION TOWNSHIP SCHOOL CORPORATION

MEDICATION CONSENT

According to Indiana P.L. 219 the Parent Authorization form must be completed before any medication can be administered.

PRESCRIPTION MEDICATION

Medication will only be given to a student provided the written authorization of the Doctor and Parent or Guardian is on file. The Pharmacy label on the prescription serves as written authorization by the Doctor.

Name____

Medication____

Dosage and Fequency of Administration____________________________

Physician's Signature ________________________ **Date** ______________

PARENT AUTHORIZATION

I authorize the building principal or his designee at my child's school to administer medication to my child. *In the case on nonprescription medication the dosage requested must not exceed the manufacturer's recommendation.*

Name____

Medication____

Dosage and Frequency of Administration____________________________

I understand that I will be responsible for supplying the medication to the school. I further understand that this authorization is valid for the duration of each such illness and that in the case of a chronic condition the authorization will be valid for the duration of the school year.

Parent Signature________________________ **Date** ________________

8/24/05