

# Saint Thomas Academy

## Consent for Administration of Medication in School

The policy of Saint Thomas Academy regarding the administration of prescription or over-the-counter medication, other than Tylenol /Ibuprofen/Tums, to students in school includes the following requirements:

1. A written order from the licensed prescriber.
2. Written parental permission for the administration of medication.
3. Medication must be in the original over-the-counter container or current, correctly labeled prescription bottle.

### NOTE:

- It is suggested that, whenever possible, medications be given at home.
- **Medication orders are required annually and when changes are made from original orders.**
- Orders may be emailed to healthforms@cadets.com or faxed to our Health Office at 651-454-4574.
- Ask your drugstore to divide the prescription medication into two (2) labeled containers -- 1 for home and 1 for school.

### Student Information

Student's Name: \_\_\_\_\_ Grade (2023-2024): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Licensed Prescriber's Order For Administration of Medication By School Personnel

I have prescribed the following medication for this student and request that the dosage(s) given during school hours be administered by school personnel under the delegation/supervision of the School Nurse.

Medication	Strength	Dose	Time	Medical Conditions	Possible Side Effects

\*\*If prescribed medication is an inhaler:

- ☐ This student will keep inhaled medication in the Health Office.
- ☐ This student is knowledgeable about and has the skills to safely possess and use an inhaler.

\_\_\_\_\_  
Print or Type Name of Licensed Prescriber

\_\_\_\_\_  
Clinic Address/City/Zip

\_\_\_\_\_  
Licensed Prescriber's Signature

\_\_\_\_\_  
Date

(\_\_\_\_\_)\_\_\_\_\_  
Phone Number

### Parent/Guardian Release for Administration of Medication

- ☐ I request and authorize school personnel, under the delegation/supervision of the School Nurse, to administer this medication as ordered by the above licensed prescriber.
- ☐ I give my permission for the School Nurse to contact the prescriber regarding questions/concerns related to my student's medication.
- ☐ I give permission for my student to carry their inhaler. I understand that the School Nurse will assess the student's knowledge and skills to safely possess and use an inhaler in the school setting.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

(\_\_\_\_\_)\_\_\_\_\_  
Phone Number