

MEDICATION POLICY

Parents are advised to give medication (prescription and non-prescription) at home on a schedule other than school hours. IF it is necessary that medication be given during school hours, the following procedure MUST be followed:

1. No medication of any form (prescription or non-prescription) will be allowed on a student's person at any time. Parents shall be responsible for personally delivering medication to the office. All medication will be stored for the student. It will be the student's responsibility to take medication at the proper time.
2. The school will not provide any medication and school personnel will not administer any medications or injections. ("Administer for the purposes of this policy does not include school personnel handling the medication to the child as per parental instruction.)
3. A Medication Log will be maintained by the school for any medication to be dispensed.
4. All medication left in the office for more than a week after last dispensing date will be disposed of. (Exceptions will be made in the case of chronic illness.)

MEDICATION PROCEDURES:

1. Parents will notify the office in writing of their request to dispense medication to their child, including all directions and special administrations, and shall supply all necessary items needed for the administration of the medication. If medication is not properly labeled, it will not be taken.
2. All medication must be self-administered or administered by the parent. If self-administered, the child must report to the office for the medication. ("Administer" for the purposes of this policy does not include school personnel handling the medication to the child as per parental instruction.)
3. The school will keep all medication in a secure place.
4. The appropriate Medication and Release from Liability form must be obtained.
5. Any medication that is required to be permanently at school for emergency situations must have a Medication and Release from Liability form submitted quarterly.
6. A Statement of Physician form will be submitted by parents in the case of medication being kept permanently at school or for chronic illness.

**REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND
RELEASE FROM LIABILITY**

I/we, the undersigned parents/guardian of the minor child, _____
_____, a student at E.D. White Catholic High School, hereby
request the school to allow said child to attend school while taking medication from
_____ to _____.

If I/we furnish any form of medication, prescription or non-prescription, it must be
labeled with said child's name, name of medication and dosage. It must be
accompanied with instructions, including the specific time it is to be taken at school. I/we
assume all responsibility for any mistake if furnishing incorrect dosage.

For and in consideration of allowing said child to attend school in spite of his/her
special needs, we hereby release, relieve and discharge E.D. White Catholic High
School, Parish and the Diocese of Houma-Thibodaux, and/or any of its agents or
employees, from any and all liability for any injury or damage to the health of said child
arising out of, or resulting from the necessity of said child having to take medication
during school hours.

I/we further release E.D. White Catholic High School, Parish and the Diocese of
Houma-Thibodaux from any and all liability whatsoever, and for any cause whatsoever
which may result from the storing of medication, prescription or non-prescription.

I/we have read, understand and agree to the school's regulations concerning
giving medications at school.

Medication _____	To be administered by:
	_____ Parent/Guardian
Dosage _____	_____ Child

Instructions _____

Signature of Parent/Guardian

Signature of Parent/Guardian

Address

Date

Phone Number

STATEMENT OF PHYSICIAN

_____ Name of Student	_____ E.D. White Catholic High School	_____ Date
_____ Diagnosis	_____ Name of Medication	_____ Dosage
_____ Time of Administration	_____ Method of Administration	
_____ Date of Discontinue	_____ Predictable Side Effects	

THIS student has been instructed in the proper method of self
ADMINISTRATION of his/her medication.

Physician's Signature

Address

Phone Number