IMMACULATE CONCEPTION SCHOOL

FROM THE SCHOOL NURSE

Dear Parents:
The policy for over the counter (OTC) medication administration in the school clinic has been updated according to the standards that are mandated by the Nurse Practice Act of Maryland. In the past, over the counter medications were dispensed with only the parent's written permission. **We will no longer be able to dispense over the counter medication without the written consent of the parent AND the student's physician**. There will be no exceptions.

The policy for Prescription medications remains the same. ***Prescription medications that need to be given to the student during the school day must be accompanied by a signed Medication Form from the prescribing physician*** and be in the original container (your pharmacist will give you a second labeled container for school if you request it).

Attached is a *CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATIONS* that gives permission from both you and your child's doctor to administer over the counter medicines to the students for occasional symptoms. You will be notified if your child receives an OTC medicine in the school clinic. Medications must be brought in original containers.

We appreciate your cooperation and ask that you call if you have any questions regarding any aspect of these policies. They are designed with the best interests of our students in mind. We look forward to a happy and healthy year for all.

Any Questions Please Contact the Nurse at 410-427-4812 or nurse@theimmaculate.org

<u>IMMACULATE CONCEPTION SCHOOL</u>

Phone: 410-427-4812   Fax: 410-427-4895

CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATIONS

Student's Name: ______________________________ Grade : ______ Date of Birth:___________

Allergies: ____

Medication currently receiving: ____

Check if Yes	**Medication**
__________	IBUPROFEN <12yrs as directed, >12yrs 200-400mg PO q4-6hr prn
__________	ACETAMINOPHEN <12yrs as directed, >12yr 650-1000mg PO q4-6h prn
__________	COUGH DROPS
__________	BENADRYL 6-12yrs-12.5mgPO q4-6hr prn; >12yrs 25-50mg PO q4-6hprn
__________	ANTACID TABLETS
__________	ANTIBIOTIC OINTMENT
__________	ANTI-ITCH LOTION or CREAM
__________	I DO NOT want any Medications given to my child at school.

Parent Signature: ______________________________Date:__________________
Phone #:____

DOCTOR'S Signature: _________________________________Office#:_________________
Print Name: ____Date:____________________