Bay Path Regional Vocational Technical High School
Office of the School Nurse
57 Old Muggett Hill Road
Charlton, Ma 01507
Phone: (508) 248-5971, X1165 or X1164
Fax: (508) 248-7183

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 students needing **prescription medicines (including Inhalers for Asthma and Epi-Pens/Benadryl for Allergic Reactions), and Over-the- Counter Medication** during the school day. Our school district requires that the following forms be on file in your student's health record **BEFORE** we can give any medication at school. **No exceptions will be made!**

1. **Signed Medication Order/Permission Form by Doctor, Nurse Practitioner and Parent/Guardian** to give prescription medication. Please have the enclosed form completed and return to the school nurse. **This form must be renewed as needed and at the beginning of each academic year.**

2. **Any over the counter medication other than Regular Strength Tylenol (Acetaminophen) or Advil (Ibuprofen) also requires a Signed Medication Order/Permission Form by Doctor, Nurse Practitioner and Parent/Guardian.** The medication must also be provided to the school nurse. Regular Strength Acetaminophen (Tylenol) 325 – 650 mg, or Ibuprofen (Advil, Motrin) 200 - 400 mg can be given with parental consent (Over the Counter consent form different than consent form for prescription medication). Over the counter consent form for Acetaminophen and Ibuprofen is available in the nurse's office.

All prescription medicines should be delivered to the school by parents or guardians in the prescription container. If this is not possible, please call the school nurse to discuss other arrangements. We cannot accept medication that is not in original prescription bottle. Please ask your pharmacy to provide separate bottles for school and home. It is requested that no more than a thirty-day supply of the medicine be delivered to the school.

When your student needs a medicine to be given during the school day, please act quickly to follow these policies so we may begin to give the medicine as soon as possible. Medication will not be given without the appropriate forms on file in the nurse's office. Thank you for your help and understanding. Please call the nurse's office with any questions.

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**********MEDICATION ORDER/PERMISSION FORM FOR SCHOOL**********

TO PRESCRIBER (Physician/Nurse Practitioner as authorized by Chapter 94C): PLEASE NOTE: This order form needs to be updated at the beginning of each school year.

The below named student MUST take Prescribed Medication during school hours.

GRADE: _____ ID#: _____

NAME OF STUDENT: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE #: _____

DIAGNOSIS: _____

MEDICATION: _____ ROUTE: _____

DOSAGE/FREQUENCY: _____

TIME DURING SCHOOL DAY TO BE GIVEN: _____

DATE MEDICATION TO BEGIN: _____ DISCONTINUATION DATE: _____

RETURN VISIT TO PHYSICIAN RECOMMENDED ON: _____

ANY OTHER MEDICAL CONDITIONS/ALLERGIES: _____

OTHER MEDICATION TAKEN BY STUDENT: _____

SIDE EFFECTS, CONTRAINDICATIONS, OR POSSIBLE ADVERSE REACTIONS TO BE OBSERVED:

_____

_____ _____

SIGNATURE OF LICENSED PRESCRIBER DATE

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**********PARENT/GUARDIAN CONSENT FORM FOR PRESCRIPTION MEDICATION**********

I hereby request that the above named medication ordered by the above Prescriber for my son/daughter _____ be administered by the school nurse.

Name

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.
I understand that this medication will be disposed of if it is not picked up within one week following termination of the order or the last day of school.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Please note that this form along with the med your child uses must be in the nurse's office on the first day of school.