Dear Parents/Guardians,

Please find important information regarding dispensing medication below. The attached form **must be completed by your doctor** if your child requires medications during school hours.

HEALTH PROCEDURES
REGARDING DISPENSING OF MEDICATION

Parent(s)/guardian(s) should administer medications at home whenever possible and should collaborate with their primary care provider to establish medication schedules that minimize administration at school. Medication, both prescribed and over-the-counter, may not be brought to school unless absolutely necessary. If it is crucial for your child to take medication during the school day, please use these guidelines:

1. Students are **NOT** permitted to possess prescription medication or over-the-counter medications at any time during the school day or at school activities/functions.
2. A parent/adult **MUST** personally deliver and pick up the medication and he/she must bring the medication to the school nurse or principal.
3. Medications will be dispensed by a school nurse or licensed health room nurse.
4. Medication **MUST** come to school in the originally prescribed container.
5. **ALL** medication, including over the counter medication **MUST** be accompanied by an "Authorization for Medication" release form signed by the parent/guardian and a physician, or license prescriber, including instructions on administration and side effects of the medication. Verbal authorization will not be accepted.
6. It is the student's responsibility to go to the office or health room for the medication. Every effort will be made to arrange an appropriate schedule with the student's teacher.

The Easton Arts Academy Elementary Charter School Health Services

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

FOR THE PHYSCIAN:

_____, DOB ____/____/_____ must receive medication
(*Student Name)*

prescribed by me for the following condition:_____.
This medication must be given during school hours in order or maintain sufficient health and participation in the school program.

Medication: _____

Prescribed daily dosage: _____

Time and dosage to be given in school: _____

Duration period: _____

Possible side effects: _____

_____ _____
Physician Signature Date

_____ _____
Physician Name PRINTED Telephone

FOR THE PARENT OR GUARDIAN:

I give permission for the Easton Arts Academy Elementary Charter School and/or their designee to administer the above medication to my son/daughter _____ as prescribed
(Student's Name)
by the physician. **I agree to deliver the medication to the school in a labeled prescription bottle**. The label shall contain the name of the medication, the prescribed dosage, the physician's name and the pharmacy. I further agree to deliver a new supply of medication to the school, as needed. I authorize the Easton Art Academy Elementary Charter School to exchange health-related information with the above named physician.

I understand that a new medication authorization form must be completed by the parent and physician if the dosage is changed at any time.

_____ _____ _____ _____
Parent or Guardian Signature Parent or Guardian Name PRINTED Telephone Number Date