St. Francis School

P.O. Box 250
244 W. Woodworth Street
Ellsworth, WI 54011-0250
Telephone: 715-273-4391
Fax: 715-273-6374
Website: www.stfrancisellsworth.org

MEDICATION POLICY

St. Francis School has a medication policy covering all prescriptive and non-prescriptive medications taken by students during school hours. The party authorized to administer the drug and the school administrator are immune from civil liability for their acts or omissions.

If it is necessary for a child to take prescriptive medication during the school day, an authorization form signed by the physician and parent/guardian must be on file in the school office. **Medication must be placed in a pharmacy labeled container with the student's name, name of medication, and dosage.** See attached Prescription Medication Form. Similar authorization forms can be found at clinics, hospitals, pharmacies, and Ellsworth Public Schools.

Students taking non-prescriptive medication, such as aspirin, cough syrup or drops, throat lozenges, etc. during school hours must have an authorization form signed by a parent/guardian on file in the school. (See attached Non-Prescriptive Medication Form) These non-prescriptive medications must be provided by the home.

Medications will be kept in a secured storage area in the school office, and dispensed in the school office by the school administrator or administrative secretary. Exceptions to this will be inhalers, and cough drops, which may be kept in the classroom. Medications will not be dispensed unless the medication policy is followed. If at all possible, parental or guardian effort should be made to administer medications before or after school.

St. Francis School

P.O. Box 250
244 W. Woodworth Street
Ellsworth, WI 54011-0250
Telephone: 715-273-4391
Fax: 715-273-6374
Website: www.stfrancisellsworth.org

PRESCRIPTION MEDICATION FORM

Name of Child: ____

Name of Medication: ____

Dosage: ____

Hours Medication Should Be Given: ____________________________________

Number of Days: ____

Special Concerns: ____

____

____

I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of such medication(s). Direct contact shall be made with me at any time you should have questions.

Physician Signature: _______________________________________ Date: ___________

****

The above medication may be given to my child.

Parent/Guardian Signature: ___________________________________ Date: ____________

St. Francis School

P.O. Box 250
244 W. Woodworth Street
Ellsworth, WI 54011-0250
Telephone: 715-273-4391
Fax: 715-273-6374
Website: www.stfrancisellsworth.org

NON-PRESCRIPTION MEDICATION FORM

Name of Child: ____

Name of Medication: ____

Dosage: ____

Hours Medication Should Be Given: ______________________________________

Number of Days: ____

Special Concerns: ____

____

____

The above medication may be given to my child.

Parent/Guardian Signature: _________________________________ Date: ____________