Pierce City Schools

Pierce City R-VI Public Schools
Authorization for Medication Administration
Parent Information About Medication Procedures

1. **Medications should be taken at home** whenever possible so that the student does not lose valuable classroom time.
2. **The first dose of any NEW medication should be administered at home**.
3. If it is necessary for the student to take medication at school, an **"Authorized for Medication Administration"** form must be received for EACH medication and must be submitted to the Health Office staff with the medication to be administered at school. Use the appropriate form for asthma, allergy, seizure and diabetes medications.
   Medication will not be accepted without the appropriate form.
4. **Medications must be brought to the health office by a parent/guardian.** Students with diabetes, asthma, or life-threatening allergies may carry the following medications (insulin, glucagon, inhalers, epinephrine auto-injectors) throughout the school day with the written consent of the physician, school nurse and parent/guardian as indicated on the "Physician Order/Action Plan." Otherwise, students are not permitted to transport medications to and from school or carry any medication while in school.
5. **Medication Containers:**
   - Prescription medications - Must be in the original pharmacy bottle with proper label containing:
     - Student's name
     - Name of medication
     - Time to be given
     - Dose or amount to be administered
     - Healthcare provider's name
     - Date
   - Non-prescription medications (OTC over-the-counter)- Must be in the original packaging and include dosage instructions.
6. Prescription information on bottle label must match the healthcare provider's information on the "Authorization for Medication Administration" form. **Ask the pharmacy to provide a properly labeled bottle for school.**
7. Staff will not cut or break pills. Parents/Guardians should cut or break pills or request the pharmacy to cut pills into the correct dose.
8. Medication must be given in its original form unless written directions from the healthcare provider or pharmacy states otherwise. For example—open capsule or crush pill and mix with applesauce, ect.
9. Medication will be given no more than 30 minutes before or after the prescribed time.
10. Non-prescription medication will only be administered according to directions on the label. If a higher dosage is required the "Authorization for Medication Administration" form must be completed and signed by the healthcare provider.
11. Medication must be stored and administered in the health office unless the criteria for self-carry are met.
12. A new "Authorization for Medication Administration" form is required at the start of the school year and each time there is a change in dosage or time at which a medication is to be taken.
13. Parents/Guardians should not bring in more than a 60-day supply of prescription medication at a time.
14. Any **herbal or natural alternative medications** (botanicals, oils, dietary or nutritional supplements, homeopathic medicine, phytomedicine, vitamins and minerals) require an "Authorization for Medication Administration" form signed by the healthcare provider and parent/guardian. This authorization does not permit the possession or use of marijuana or unregulated CBD or THC-A oil.
15. **Unused medication MUST be picked up by a parent/guardian on the last day of school or it will be destroyed.**

Pierce City Schools

Date: _____

Parent/Guardian Authorization of Medication at School

(complete one form for each medication)

Student Name: _____DOB: _____ Grade _____

<u>Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.</u>

Medication administration during school hours requires the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medication with strength, dosage and directions; name of prescribing physician and date)
- Medication label has the student's first and last name
- The first dose of this medication for the current condition/illness **<u>may not be given at school.</u>**

Please complete the following:

Med Name and Strength (only 1 med per page)	Dosage	Time(s) to be given at school	How it's taken (mouth, eye, skin, ect)	Reason/Medical condition for med administration

Medication Start Date: _____ Medication Stop Date: _____

Note: the first dose of any medication may NOT be given at school

Has the student received this medication before? Yes _____ No _____

If Yes, Date and Time of last dose given _____

1. I request that the above medication be given during school hours as ordered by the physician. I also request that the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication (dosage, time, ect).
4. I give permission for the school nurse to communicate, as needed, with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for the medication to be given by trained personnel as delegated by the Principal.

Please Note: Elementary school students may not carry medication home (except inhalers) and should not transport controlled substances to school, including ADD/ADHD medication; all medication must be transferred from adult to adult.

I understand I am responsible for retrieving the mediation from the School Health Office when it is no longer needed or when the school year ends.

_____ _____

Parent/Guardian Printed Name Phone Number

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Reviewed by RN: _____ Date: _____

Pierce City Schools

Year: _____

Parent/Guardian Authorization for Antihistamine at School

(complete one form for each medication)

Student Name: _____DOB: _____ Grade _____

<u>Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.</u>

Medication administration during school hours requires the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medication with strength, dosage and directions; name of prescribing physician and date)
- Medication label has the student's first and last name
- The first dose of this medication for the current condition/illness **<u>may not be given at school.</u>**

Please complete the following:

Med Name and Strength (only 1 med per page)	Dosage	Time(s) to be given at school	How it's taken (mouth, eye, skin, ect)	Reason/Medical condition for med administration

Medication Start Date: _____ Medication Stop Date: _____

Note: the first dose of any medication may NOT be given at school

Has the student received this medication before? Yes _____ No _____

If Yes, Date and Time of last dose given _____

1. I request that the above medication be given during school hours as ordered by the physician. I also request that the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication (dosage, time, ect).
4. I give permission for the school nurse to communicate, as needed, with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for the medication to be given by trained personnel as delegated by the Principal.

Please Note: Elementary school students may not carry medication home (except inhalers) and should not transport controlled substances to school, including ADD/ADHD medication; all medication must be transferred from adult to adult.

I understand I am responsible for retrieving the mediation from the School Health Office when it is no longer needed or when the school year ends.

_____ _____

Parent/Guardian Printed Name Phone Number

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Reviewed by RN: _____ Date: _____

Pierce City Schools

Year: _____

Epinephrine Procedural Information with Parental/Guardian and Student Consent to Carry and Self-Administer

Student's Name_____ DOB_____ Grade_____

Information about Epinephrine Procedures

- Please notify the teacher, sponsor or coach about your child's allergy when your child will be staying for any school-sponsored after school activities.
- The health office is closed after dismissal and the school nurse is not in the building. It is suggested that the middle and high school students who are involved in these after school activities carry their own auto-injector for quick access to epinephrine.

_____ _____

Parent/Guardian Signature Date

Parent/Student Agreement for Permission to Self-Administer and/or Carry Epinephrine

PARENT:

- I give my consent for my child to self-administer and/or carry self-carry his/her auto-injector of epinephrine.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of epinephrine.
- This permission to self-administer and/or possess epinephrine may be revoked by the principal if it is determined that your child is not safely and effectively carrying and/or self-administering the medication.
- **A new Physician Order/Care Plan for Severe Allergy (along with physician authorization to carry med) and Parent/Student Agreement for Permission to Carry Epinephrine must be submitted each school year.**

_____ _____

Parent/Guardian Signature Date

STUDENT:

- If I am to self-administer, I have demonstrated the correct use of an auto-injector of epinephrine to the school nurse.
- I agree to never share my epinephrine with another person or use it in an unsafe manner.
- I agree that if I inject epinephrine I will immediately report to the school nurse or another appropriate adult if the school nurse if not available so that EMS can be called as indicated.

_____ _____

Student's Signature Date