VALLEY CITY PUBLIC SCHOOL DISTRICT #2 VALLEY CITY, NORTH DAKOTA 58072 SCHOOL MEDICATION PROVIDER OPT-OUT OR OPT-IN AND VERIFICATION OF ELIGIBILITY FORM	Descriptor Code ACBD-E1	1st Reading 8/9/18
	Adopted 8/9/18	Revised/Rescinded

SCHOOL MEDICATION PROVIDER OPT-OUT OR OPT-IN AND VERIFICATION OF ELIGIBILITY FORM

***INSTRUCTIONS**: Initial the option that applies.*

OPTION ONE: OPT-OUT

☐ I choose to opt-out of providing medication to students for the 20__-__ school year. I understand that I am prohibited from providing students any type of medication, whether prescription or over-the-counter, whenever serving in my official capacity for the school, and I may be subject to disciplinary action for violating this prohibition. I also understand that if I wish to retract this opt-out request, I must first meet the district's qualification standards for eligible medication providers, which include education and training in providing medication, receive authorization from my Superintendent.

Superintendent and receive parental consent. _____ (initials)

OPTION TWO: OPT-IN AND VERIFICATION OF ELIGIBILITY

☐ I agree to serve as a school medication provider for the _____ School for the duration of the school year. I have completed the required education and training to perform this responsibility, including education and training in the following areas:

a. The scope of my authority and my role in providing medication.
b. Proper medication storage, inventory, and disposal.
c. Proper techniques for providing medication including, but not limited to, understanding pharmacy labels, standard precautions for infection control (e.g., hand washing), six rights of medication administration, and measuring and dispensing protocols.
d. Appropriate documentation of all medication provided and confidentiality requirements.
e. Basic medical terminology related to providing medication.
f. Appropriate action if unusual circumstances occur (e.g., medication error, adverse reactions, student refusal) and how and when to seek medical consultation or assistance.

I agree to provide medication in accordance with district policy and regulations only after I have received authorization from my Superintendent.

_____
Employee/volunteer's name

_____ _____
Employee/volunteer's signature Date

TO BE COMPLETED BY SCHOOL ADMINISTRATION

Date form received by Superintendent: _____

Date of last criminal history record check: _____

Employee/volunteer received satisfactory adjudication on criminal history record check for purposes of providing medication? ☐ Yes ☐ No

Employee/volunteer eligible to serve as school medication provider[1]: ☐Yes ☐No

_____ _____
Signature of Superintendent Date

[1] If policy requires the superintendent's or board's approval to authorize school medication providers, submit this completed form to this party for final approval.