



## Guidelines for Medication Given at School

It is best for medication to be administered at home. However, under certain conditions, it is in the best educational and health interest of the child to take medication during the school day. We are asking for your cooperation regarding giving medications in school. Because of the responsibility placed upon the staff for giving the correct medications, we ask that you comply with the following guidelines.

### I. All Medication

- The **authorization form** must be completed and signed by the **health care provider and parent**.
- **No medication** shall be given without an authorization form.
- Medications must be brought to the school office by the parent and **not the student**.
- **Pills need to be broken prior to being brought to school for half dosages.**
- Medication left at school shall be destroyed the last day of school.

### II. Prescription Medication

- All medication must be in the **original prescription container or package** and properly labeled with the student's name, name of medication, exact dosage, name of health care provider, date and time of day to be given.
- The directions of the 'Authorization' form **must match** the directions on the prescription container or package.
- **Sample** medication must also be properly labeled and in the original container or package.
- **No more than a 20 (twenty) day supply of Schedules II-V medications** (i.e. ADHD medications, narcotic pain medications) should be brought to school by the parent.

### III. Administering Medication 15 Days or Less

- The **appropriate authorization form** must be completed and signed by the **parent**.
- The **health care provider** must write, on either a prescription blank or an 'Authorization' form, a request for medication to be administered at school.

### IV. Administering Medication 15 Days or More

- The **appropriate authorization form** must be completed and signed by the parent and health care provider.
- The authorization form must contain complete physician instructions.

### V. Injectable Medication

- **Injectable medications – May only be given by a licensed nurse, the student, or a parent/guardian except as listed below:**
  - If a student is susceptible to a predetermined, life-endangering situation, trained school personnel may assist the student with an auto-injection (i.e. EpiPen<sup>®</sup>, Auvi-Q<sup>™</sup>). The health care provider **and** parent must state in writing on the "Severe Allergic Reaction Plan & Medication Orders" form if the student is to **carry** an epinephrine autoinjector.
  - The parents of a student with diabetes may authorize a Parent Designated Adult (PDA) who may or may not be a school district employee, to give injections and/or administer blood glucose monitoring. The PDA must receive additional training from a health care professional or expert in diabetic care selected by the parents.

**I HAVE READ THESE GUIDELINES FOR MEDICATION GIVEN AT VALLEY CHRISTIAN SCHOOL**

Parent Signature:

Date:

# Authorization for Administration of Medication at School

Student Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Grade: \_\_\_\_\_

## This portion to be Completed by Licensed Health Professional (LHP) with Prescriptive Authority

Name of Medication	Dosage	Methods of Administration	Time of day to be taken

**Diagnosis:** \_\_\_\_\_

If given 'as needed' (prn), specify the length of time between doses: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_

Emergency procedure in case of serious side effects: \_\_\_\_\_

*I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year), as there exists a valid health reason that makes administration of the medication advisable during school hours.*

Licensed Health Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

## This Portion to be Completed by the Parent/Guardian

I have reviewed the parent information regarding medication at school and request/authorize the school to administer medication to my student in accordance with the LHP's instructions for the period from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year). I understand that due to the schedule and other responsibilities, it is possible for a dosage(s) to be delayed or missed.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Home phone #: \_\_\_\_\_

Work/cell phone #: \_\_\_\_\_

**This record must be kept for a period of 8 years**