POPE JOHN XXIII
MIDDLE SCHOOL

POLICY FOR ADMINISTRATION OF PRESCRIPTION AND OVER-THE-COUNTER MEDICATION IN SCHOOL

PJMS policy as per state mandated requirements:

1. A written order from your healthcare provider including diagnosis, name of medication, dosage, and time to be given. It must be signed, stamped, and dated by your healthcare provider. List any known allergies. Use the Order Form For Prescription Or Over-The-Counter Medication To Be Administered At School.
   Use the Physician's Over-The-Counter Medication Order Form for the five listed medications in stock at PJMS, as per standing orders.

2. Use the separate order forms for Epinephrine (3 pages) or Inhaler (2 pages) and check off permission to self-administer, or not approved to self-administer.

3. Parent's signature and date on all forms confirming consent for nurse to administer the medication.

4. The medication must be in the original pharmacy labeled container, and transported to and from school by an authorized adult. Students are not permitted to transport medication.

5. Students are not permitted to self-medicate with any prescription medication except for pre-approved Epinephrine or Inhaler. Students are not permitted to take lozenges or self-medicate with any other over-the-counter remedies or medications.

6. All medication orders must be renewed at the beginning of each school year.

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MIDDLE SCHOOL

ORDER FORM FOR PRESCRIPTION OR OVER-THE-COUNTER MEDICATION TO BE ADMINISTERED AT SCHOOL

(Use separate order forms: 1. Allergy Action Plan for Epinephrine/Delegate Orders/Consent -3 pages 2. Asthma Treatment Plan for Inhaler -2 pages)

Student:_____ Gr._____ D.O.B_____

Allergies:_____

Diagnosis:_____

Medication:_____

Dosage:_____

Time:_____

Healthcare Provider's Signature:_____

Date:_____

Healthcare Provider's Address Stamp:

The School Nurse has my permission to administer the above medication to my child:

Parent's Signature:_____

Phone:_____

Date:_____

POPE JOHN XXIII
MIDDLE SCHOOL

PHYSICIAN'S OVER-THE-COUNTER MEDICATION ORDER FORM

_____(student's name) Gr._____D.O.B._____
may receive the following medications indicated by a check mark during school hours in the health office. **THESE MEDICATIONS ARE CURRENTLY IN STOCK AS PER STANDING ORDERS**.

( ) Acetaminophen 325 mg tablets or 160mg elixir or chewables as indicated on the label, as needed for minor aches, pain, headaches or a fever > 100.

( ) Ibuprofen 200mg tablets or 100mg elixir or chewables as indicated on the label, as needed for minor aches, pain, headaches or a fever > 100.

( ) Antacid 500mg chewable tablets. May take 1-2 chewables as indicated on the label, as needed for acid indigestion or heartburn.

( ) Benadryl 25 mg tablet. May take ½ , or 1, or 2 tablets as indicated on the label, as needed for allergic reaction. May take Benadryl Chewables or Elixir as indicated on the label in lieu of tablets.

( ) Zaditor Antihistamine Eye Drops as directed for allergy/irritation.

Healthcare Provider's Signature: _____

Date: _____ Address Stamp: _____

I, _____(parent's signature) hereby give my permission for the nurse to dispense the medication indicated for my child when necessary. My child has no allergies to these medications.

Date: _____