

Hitchcock Independent School District Administration of Medications at School

Parents/Guardians,

Effective, 08/01/2020, all **“OVER-THE-COUNTER” (OTC)** Medications (ie: Tylenol, Ibuprofen, Midol, creams and/or ointments, etc.) **will require a written prescription from the student’s health care provider.** This change has been prompted by the continued challenges of COVID-19. With our children’s health and safety as our primary concerns, OTC medications such as Tylenol, Ibuprofen, and other fever reducing medications have the ability to mask the symptoms of the Coronavirus infection (fever, headache, cough, etc.).

1 .All prescription medications administered during school hours MUST contain the following information:

- a. The student’s full name clearly printed on the prescription label
- b. The physician’s name
- c. The name and strength of the medication, in the original prescription container
- d. Dosage, frequency, and duration of administration
- e. Diagnosis/condition for medication to be administered, as needed (ie: onset of headaches, menstrual cramps, etc.)
- f. Current prescription (past 12 months), filled in U.S. Pharmacy (Insulin, Epi-pens, Inhalers, etc.)

2. Medications are strongly encouraged to be taken at home around school hours with exception of Asthma inhalers, Anaphylactic emergency medications, and Insulin (ie: **three times daily meds...before school, after school, and at bedtime; morning meds before school. Morning medications can be administered at home before school with a small snack.**

3. Any medication needed at school, **MUST** be brought to the school clinic by **parent/guardian**. All medications must be provided by parent/guardian. OTC medication must be in new sealed container and non-expired.

4. Students may not be in possession of any medications during school hours or at school-sponsored or school-related activities, on or off campus unless prior authorized (ie: Asthma inhaler, Epi-pen, Diabetic meds).

5. Hitchcock ISD cannot administer any medications that are expired, or that considered to be “herbal,” “homeopathic,” or an “alternative” type of medication.

6. Narcotics (prescription pain medications) will NOT be administered at school.

7. In accordance with the Texas Nurse Practice Act, Rule 217.11, the school nurse has the responsibility and authority to clarify any medication order with appropriate licensed practitioner and/or refuse to administer medication that, in the nurse’s judgment, is not in the best interest of the student.

Permission to Administer Prescription Medication at School

Student name (Last)	(First)	(MI)	DOB	Grade
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Medication <input type="checkbox"/> Prescription #1		Name of Medication and Dosage		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given	
Reason medication is being given (MEDICAL DIAGNOSIS)				
Form of Medication <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Insulin <input type="checkbox"/> Epi-pen <input type="checkbox"/> Other (list)		Asthma Inhaler / Student educated and may self-carry <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin / Student educated and may self-administer <input type="checkbox"/> Yes <input type="checkbox"/> No Epi-pen / Student educated and may self-administer <input type="checkbox"/> Yes <input type="checkbox"/> No		

I have read the information contained in this Medication Document and it is accurate and true to the best of my knowledge. I also understand that under TEC rules, the Campus Principal is charged with the responsibility of assigning the task of “Medication Administration.” NOTE: This employee may or may not be a Registered Nurse or a Certified Nurse Aide. In addition, it is not the responsibility of the school to notify the parent/guardian for the need of a refill. Each campus may handle this differently (ie: written note, phone call, email, text, etc.). As the parent of a student for which I have given permission to the school/school employee to administer medications during school hours, I release Hitchcock ISD of responsibility and liability for missed doses, refusals by student to take medication, absences or “no show” for designated medication time, adverse reactions, and any other risks associated with administering listed medication(s) at school.

Parent/Guardian Name	Parent/Guardian Signature	Date
Mobile Phone	Home Phone	Work Phone

Permission to Administer Prescription Medication at School

Student name (Last)	(First)	(MI)	DOB	Grade
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Medication <input type="checkbox"/> Prescription #2		Name of Medication and Dosage		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given	
Reason medication is being given (MEDICAL DIAGNOSIS)				
Form of Medication <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Insulin <input type="checkbox"/> Other (list)		Asthma Inhaler / Student educated and may self-carry <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin / Student educated and may self-administer <input type="checkbox"/> Yes <input type="checkbox"/> No		

Medication <input type="checkbox"/> Prescription #3		Name of Medication and Dosage		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given	
Reason medication is being given (MEDICAL DIAGNOSIS)				
Form of Medication <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Insulin <input type="checkbox"/> Other (list)		Asthma Inhaler / Student educated and may self-carry <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin / Student educated and may self-administer <input type="checkbox"/> Yes <input type="checkbox"/> No		

Medication <input type="checkbox"/> Prescription #4		Name of Medication and Dosage		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given	
Reason medication is being given (MEDICAL DIAGNOSIS)				
Form of Medication <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Other (list)		Asthma Inhaler / Student educated and may self-carry <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Parent/Guardian Name	Parent/Guardian Signature	Date
Mobile Phone	Home Phone	Work Phone