

## CLSD Medication Information

The Canfield Board of Education, as mandated by the State of Ohio, has a medication policy for the entire school system. In order for the school to give medication to your child, several procedures **MUST** be followed. Students are not allowed to carry any medication in the school unless the proper forms are completed, signed by both the parent and the physician. If it is medically necessary for a student to have medication during the school day, the parent must bring that medication to the school and complete the necessary medication forms. When these forms are completed, the nurse or a person designated by the principal of that school will administer the medication. Only inhalers, epi-pens and diabetic needs may be carried by students if the proper medication forms are completed, signed by both the parent and the physician. This includes over the counter medications. The school nurse may administer several over the counter medications such as Tylenol. Only the school nurse can administer these school-purchased, over the counter medications from the nurse's office. If you have any questions concerning this policy, please call the school.

### Medication Procedure

1. The medication must be brought to the school by the parent or guardian.
2. The medication must be in the original container from the pharmacy.
3. The medication must be labeled with the medication's name, the physician's name and your child's name, and time to be given.
4. The "Parent Request and Authorization to Administer a Prescribed Medication or Treatment" form must be completed and signed by the parent or guardian and must include the signature of the physician.
5. New forms must be completed each school year.
6. Any medication not picked up by the parent or guardian by the end of each school year will be disposed of by the School Nurse.
7. Any medication brought in by a parent in a baggie or inappropriate container with a note will **NOT** be given to the student.

What medications can your child have in the school? Any medication, either prescription or **over the counter, that is medically necessary for your child to remain in school**, can be given to your child at school as long as the proper paperwork has been completed and is signed by a parent AND THE PHYSICIAN. The medication must be delivered to the school by the parent and can only be given to your child by the nurse or the trained, designated employee. Students cannot carry any medications with them or in their lunch, purse, or backpack. The **ONLY** medications students are allowed to carry on their person, and only if the proper paperwork is in the nurse's office, are inhalers for asthma, epi-pens for anaphylactic reactions, and insulin and testing materials for diabetes.

The school does keep a small supply of over the counter medications such as Tylenol. This medication can be given by the nurse after an assessment. The distribution of over the counter medications that are in the nurse's office and are given by a nurse do not require any paperwork on the part of the parent, but can only be given when the nurse is in the building. **Cough drops, vitamin drops, and throat lozenges are not used in the elementary schools.** If you have any questions about the regulations or any questions concerning your child and medication, call the nurse at your school.

Canfield Local School: Main Number 330-533-3303 then dial the appropriate extension:

High School:	Nurse Beck 72004
Middle School:	Nurse Billingsley 77013
Hilltop:	Nurse Milligan 75176
C.H. Campbell:	Nurse Pool 74037

AUTHORIZATION FOR PRESCRIBED  
MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Address

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade

A. I am requesting permission for my child named above to: (Check all that apply)

\_\_\_\_\_ use or receive prescribed medication

\_\_\_\_\_ receive prescribed treatment

\_\_\_\_\_ self-administer prescribed medication(s) in my presence or that of an authorized staff member

\_\_\_\_\_ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

I have prescribed the following medication \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

Dosage, instructions, or precautions (including possible side effects): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have prescribed the following treatment \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

**For student with diabetes only:**

\_\_\_\_\_ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

\_\_\_\_\_ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature \_\_\_\_\_ Telephone \_\_\_\_\_

Printed/Typed Name \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR STAFF**

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Principal

11/19/14