

Medication at School

Each school principal will authorize two (2) staff members to administer prescribed or non-prescribed medication. These designated staff members will receive RN delegation prior to the opening of school each year.

For purposes of this procedure, “medication” means oral medication, topical medication, eye drops, ear drops and nasal spray. Oral medications are administered by mouth either by swallowing or by inhaling and may include administration by mask if the mask covers the mouth or mouth and nose.

Medication may be dispensed to students on a scheduled basis upon written authorization from a parent with a written request by a licensed health professional prescribing within the scope of their prescriptive authority. If the medication is to be administered more than fifteen (15) consecutive days, the written request must be accompanied by written instructions from a licensed health professional. Requests will be valid for not more than the current school year. The prescribed or over-the-counter medication must be properly labeled and be contained in the original container. The dispenser of prescribed or non-prescribed oral medication will:

1. Collect the medication directly from the parent (students should not transport medication to school), collect an authorization form properly signed by the parent and by the prescribing licensed health professional and collect instructions from the prescribing licensed health professional if the medication is to be administered for more than fifteen (15) consecutive days;
2. Store the prescription or non-prescribed medication (not more than a twenty (20) day supply) in a locked, substantially constructed cabinet;
3. Maintain a daily record which indicates that the prescribed or non-prescribed medication was dispensed; and
4. Provide for delegation, training and supervision by a physician or registered nurse.

A copy of this policy and procedure will be provided to the parent upon request.

Prescribed and over-the-counter oral or topical medications, eye drops or ear drops may be administered by a registered nurse, a licensed practical nurse or an authorized staff member.

Nasal sprays containing legend (prescription) drugs or controlled substances may only be administered by a school nurse or, if a school nurse is not present on school premises, an authorized school employee; or a parent-designated adult with training as required by RCW 28A.210.260.

No prescribed medication will be administered by injection by staff except when a student is susceptible to a predetermined, life-endangering situation. The parent will submit a written statement which grants a staff member the authority to act according to the specific written orders and supporting directions provided by a licensed health professional prescribing within his or her prescriptive authority (e.g., medication administered to counteract a reaction to an insect sting). Such medication will be administered by staff trained by the supervising registered nurse to administer such an injection.

Written orders for emergency medication, signed and dated, from the licensed health professional prescribing within his or her prescriptive authority will:

1. State that the student suffers from an allergy which may result in an anaphylactic reaction;

2. Identify the drug, the mode of administration, and the dose. Epinephrine administered by inhalation, rather than injection, may be a treatment option. This decision must be made by the licensed health professional prescribing within his or her prescriptive authority;
3. Indicate when the injection will be administered based on anticipated symptoms or time lapse from exposure to the allergen;
4. Recommend follow-up after administration, which may include care of the stinger, administration of additional medications, transport to hospital; and
5. Specify how to report to the health professional prescribing within his or her prescriptive authority and any record keeping recommendations.

If a health professional and a student's parent requests that a student be permitted to carry his/or her own medication and/or be permitted to self-administer the medication, the principal may grant permission after consulting with the school nurse. The process for requesting and providing instructions will be the same as established for oral medications. The principal and nurse will take into account the age, maturity and capability of the student; the nature of the medication; the circumstances under which the student will or may have to self-administer the medication and other issues relevant in the specific case before authorizing a student to carry and/or self-administer medication at school. Except in the case of multi-dose devices (like asthma inhalers), students will only carry one day's supply of medication at a time. Violations of any conditions placed on the student permitted to carry and/or self-administer his or her own medication may result in termination of that permission, as well as the imposition of discipline when appropriate.

Parent-Designated Adult Care of Students with Epilepsy:

Parents of students with epilepsy may designate an adult to provide care for their student consistent with the student's individual health care plan. At parent request, school district employees may volunteer to be a parent-designated adult under this policy, but they will not be required to participate.

Parent-designated adults who are school employees will file a voluntary, written, current and unexpired letter of intent stating their willingness to be a parent-designated adult. Parent-designated adults who are school employees are required to receive training in caring for students with epilepsy from the school nurse. Parent-designated adults will receive additional training from a parent-selected health care professional or expert in epileptic care to provide the care (including medication administration) requested by the parent.

Parent-designated adults who are not school employees are required to show evidence of comparable training, and meet school district requirements for volunteers. Parent-designated adults will receive additional training from a parent-selected health care professional or expert in epileptic care to provide the care requested by the parent. The District is not responsible for the supervision of procedures authorized by the parents and carried out by the parent-designated adult.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name _____ Birthdate _____

School _____ Grade _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Medication</u>	<u>Time of Day to Be Taken</u>
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_____	_____	_____	_____
_____	_____	_____	_____

If given prn, specify the length of time between doses _____

Inhalers: _____

Indicate if student must carry on his/her person

Student is capable to self-administration of medication _____ Yes _____ No

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

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

Date of Signature_____
Licensed Health Professional Signature

Telephone Number: _____

Name: _____
(print or type)

Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above-identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry medication _____ Yes _____ No

Permission to self-administer medication _____ Yes _____ No

Date of Signature_____
Parent/Guardian Signature

Telephone number: _____ (home) _____ (work)

MEDICATIONS LOG – USE ONE SHEET FOR EACH STUDENT

Name _____ Birthdate _____ School _____ Grade _____

Medication(s) & Dose _____ Parent or Guardian _____ Teacher _____

Licensed Health Professional _____ Professional's Phone Number _____

	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
September	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
October	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
November	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
December	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
January	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									

If student is absent or medication not given, record such in appropriate box. The person assisting with the medication signs their initials in the block under the corresponding day of the week.

Signature	Initials	Date	Signature	Initials	Date

Codes: A = Absent E = Early Dismissal N/A = Not Available

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	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
February	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
March	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
April	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
May	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									
June	Week of					Week of					Week of					Week of					Week of				
Initial																									
Times																									

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MEDICATION ERROR REPORT FORM

Student: _____ DOB: _____

School building: _____ Grade: _____ Date of Error: _____

Medication: _____ Dosage: _____ Time to be given: _____

Reason for report: (missed medication, wrong time, wrong student, wrong route, wrong dose, wrong medication)

Action taken/intervention:

Nurse supervisor: _____ Notified: ☐ Yes ☐ No

Time and date of notification: _____

Name of parent/guardian notified: _____ Time and date: _____
(if instructed to do so by RN)Student's physician notified: _____ Time and date: _____
(by RN)

Nurse supervisor's signature: _____ Date: _____

Witness(es): _____

Name of person preparing report (please print): _____

Signature of person preparing report: _____

Follow-up contact/care: _____

Form should be completed in ink as it is a legal record. Do not use "white out," correction tape, eraser, etc. to correct recording errors. Draw a single line through the error, record the correct information, and initial the corrected entry. The completed form is to be sent to the supervising nurse and a copy maintained in the employee's file in a designated location.

Date: _____

Re: _____

Medication: _____

Dear Parent:

We are making plans to close out the school year. This includes seeing that the medication your child may have left over will get home in a safe manner. Please make arrangements to **pick up** the medication at school. Any medication left in the building after _____ will be destroyed.

If your child needs to take medication during school hours next school year, another medication authorization form from your child's health care provider will need to be completed before school starts in the fall. Please bring the completed medication authorization, the medication in the pharmacy container with your child's name, the medication name, and the dose and time to be given. Thank you for your cooperation in helping to keep your child safe at school.

Thank you for your cooperation.

Paraeducator – Health Room

FIELD TRIP MEDICATION

Student's Name: _____ Age: _____

Teacher: _____ Grade: _____

Medication: _____ Dosage: _____

Time to be given: _____ Date: _____

Person giving medication: _____
(signature)

Date and time medication was given: _____
(date) (time) (initial)

Please return this paper to the health room after the field trip. The nurse will transfer the information to the student medication log and verify any medication returned to the health room. Thank you.