

## LPS Emergency Medication/Treatment Self-Administration Packet

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication/Treatment:

- Rescue Inhaler \_\_\_\_\_
- Epinephrine \_\_\_\_\_  Call 911 upon administering
- Insulin \_\_\_\_\_
- Diabetic Medications \_\_\_\_\_
- Other \_\_\_\_\_

I, a licensed physician or nurse practitioner, certify that this child has a medical history of \_\_\_\_\_, a chronic medical condition; has been trained in the use of the listed medication/treatment; and is capable of carrying and self-administering the listed medication/treatment. The child should notify school staff if medications/treatments are used but condition is not improved. The child understands the hazards of sharing medications with others and agrees to use medication/treatment as prescribed.

Signature of health care provider: \_\_\_\_\_ Date: \_\_\_\_\_

Name of health care provider: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Physician signature required for initial authorization only

I, the parent or legal guardian of the student listed above, give permission for my child to carry and self-administer the above listed medications/treatments. I have instructed my child to notify the school staff if medications/treatments are used but condition is not improved. I understand that, absent any negligence, the school shall incur no liability as a result of any injury arising from the self-administration of medication by my child. This permission can be revised if there is evidence that the student is not administering medication appropriately.

I have been offered a copy of Missouri Revised Statute Chapter 167 Section 167.627.1 abbreviated and Liberty Public Schools Board Policy for Administration of Medication to Students (JHCD).

Printed Name of Parent or Legal Guardian: \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\*Parent signature required yearly on Annual Authorization Form and Medication Authorization Form.

Student has demonstrated proper use to the school nurse. \_\_\_\_\_  
(School Nurse's Signature)

# Self-Administration Skills Checklist for Students with Diabetes

**Student's Name:** \_\_\_\_\_ **School Year:** \_\_\_\_\_

Student has demonstrated understanding of competency of the following:

1. States signs and symptoms of low blood sugar and when to tell the teacher or nurse Yes \_\_\_\_\_ No \_\_\_\_\_
2. States appropriate treatments for low blood sugar Yes \_\_\_\_\_ No \_\_\_\_\_
3. States signs and symptoms of high blood sugar and when to tell the teacher or nurse Yes \_\_\_\_\_ No \_\_\_\_\_
4. States appropriate treatments for high blood sugar Yes \_\_\_\_\_ No \_\_\_\_\_
5. Demonstrates how to monitor blood sugar Using Dexcom Yes \_\_\_\_\_ No \_\_\_\_\_
6. States when to check blood sugar using the glucometer Yes \_\_\_\_\_ No \_\_\_\_\_
7. States when extra carbs are needed such as For PE and/or recess. Yes \_\_\_\_\_ No \_\_\_\_\_
8. States the expected normal blood sugar range established per action plan Yes \_\_\_\_\_ No \_\_\_\_\_
9. States at what glucose level ketones should be checked Yes \_\_\_\_\_ No \_\_\_\_\_
10. Demonstrates proper technique when testing with the glucometer Yes \_\_\_\_\_ No \_\_\_\_\_
11. Demonstrates how to calculate carbs for meals and/or snacks Yes \_\_\_\_\_ No \_\_\_\_\_
12. Demonstrates how to properly dose for snacks and meals using the pump Yes \_\_\_\_\_ No \_\_\_\_\_
13. States other times that it is expected that student notify the teacher/nurse during the school day related to diabetes care (site comes off, pump Malfunction, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_

14. Other: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Review Date(s): \_\_\_\_\_

**Missouri Revised Statutes - August 28, 2016**

**Chapter 167: Pupils and Special Services: Section 167.627.1**

**Possession and self-administration of medication in school--requirements.**

167.627. 1. For purposes of this section, the following terms shall mean:

- (1) "**Medication**", any medicine prescribed or ordered by a physician for the treatment of asthma or anaphylaxis, including without limitation inhaled bronchodilators and auto-injectable epinephrine;
- (2) "**Self-administration**", a pupil's discretionary use of medication prescribed by a physician or under a written treatment plan from a physician.

2. Each board of education and its employees and agents in this state shall grant any pupil in the school authorization for the possession and self-administration of medication to treat such pupil's chronic health condition, including but not limited to asthma or anaphylaxis if:

- (1) A licensed physician prescribed or ordered such medication for use by the pupil and instructed such pupil in the correct and responsible use of such medication;
- (2) The pupil has demonstrated to the pupil's licensed physician or the licensed physician's designee, and the school nurse, if available, the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered;
- (3) The pupil's physician has approved and signed a written treatment plan for managing the pupil's chronic health condition, including asthma or anaphylaxis episodes and for medication for use by the pupil. Such plan shall include a statement that the pupil is capable of self-administering the medication under the treatment

plan;

- (4) The pupil's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan required under subdivision (3) of this subsection and the liability statement required under subdivision (5) of this subsection; and
- (5) The pupil's parent or guardian has signed a statement acknowledging that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil or the administration of such medication by school staff. Such statement shall not be construed to release the school district and its employees or agents from liability for negligence.

3. An authorization granted under subsection 2 of this section shall:

- (1) Permit such pupil to possess and self-administer such pupil's medication while in school, at a school-sponsored activity, and in transit to or from school or school-sponsored activity; and
- (2) Be effective only for the same school and school year for which it is granted. Such authorization shall be renewed by the pupil's parent or guardian each subsequent school year in accordance with this section.

4. Any current duplicate prescription medication, if provided by a pupil's parent or guardian or by the school, shall be kept at a pupil's school in a location at which the pupil or school staff has immediate access in the event of an asthma or anaphylaxis emergency.

5. The information described in subdivisions (3) and (4) of subsection 2 of this section shall be kept on file at the pupil's school in a location easily accessible in the event of an emergency.

# Liberty Public Schools Medication Authorization Form

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

Start Date	Medication	Dosage	Time	End Date

I consent to allow district staff to give medication to my child and understand that the Liberty School District No. 53 Board of Education, employees, and volunteers are not to be held responsible or liable in the event of injury resulting from medication given by district staff.

**FOR GRADES 6 - 12 ONLY: ACETAMINOPHEN (Generic Tylenol) PERMISSION**  
 Must check 'yes' or 'no' and provide signature below.

Yes     No    I give permission for my child to take Acetaminophen 325mg (1 - 2 tablets) every 4 hours as needed during the school day. No more than 25 doses will be given in a school year without a doctor's note.

**Medication should be given at home whenever possible.** If medications must be given during the school day, the following will apply\*:

1. Medicine must be in the original and current prescription bottle or original packaging.
2. Staff will not give the first dose of any medication unless it is an emergency.
3. Expired medications will not be given.
4. Over-the-counter medications are given according to the dosing directions on the bottle. Any other dosage must have an order from the doctor.
5. Medications or supplements not approved by the FDA (e.g., herbal remedies) require written permission from the parent and an order from the doctor.
6. Unless otherwise noted above, all medication authorizations will extend through summer school.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent/Guardian)