**MEDICATION ADMINISTRATION**

The Fargo Public School District has established a program for providing medication to students during the school day and when students are otherwise under the district's direct supervision (e.g., participating in a school activity, on a school-sponsored trip). This program is only available to students when the applicable requirements under this policy have been satisfied.

**Qualifications for Eligible School Medication Providers**
In order to be eligible to provide medication under this policy, an individual must meet the following criteria and receive approval from the building principal.

1. Received education and training in medication administration, including the following topics:
    a. Individual's authority and role in providing medication
    b. Proper medication storage, inventory, and disposal
    c. Proper techniques for providing medication including, but not limited to, understanding pharmacy labels, standard precautions for infection control (e.g., hand washing), six rights of medication administration, and measuring and dispensing protocols
    d. Appropriate documentation of all medication provided and confidentiality requirements
    e. Basic medical terminology related to providing medication
    f. Appropriate action if unusual circumstances occur (e.g., medication error, adverse reactions, student refusal) and how and when to seek medical consultation or assistance
2. Provided the building principal with verification that the above training and education is complete
3. Undergone a criminal history record check through the District and received satisfactory adjudication
4. Agreed to perform the duty of providing medication for at least the duration of the school year
5. Received written consent of the student's parent or guardian
6. Agreed to comply with this policy and any additional district rules on providing medication
7. The school medication provider will yearly complete the opt-out or opt – in and verification of eligibility form (AF 6720-H) and will be filed with the building principal.

The District shall pay the cost of all district-authorized education and training for school medication providers.

**Requirements and Prohibitions for all School Personnel**
All school employees shall comply with the district's Drug and Alcohol Free Workplace policy, which prohibits illegal activities associated with prescription and over-the-counter medication. In addition, eligible school medication providers and all other school employees with knowledge of a student's health condition and/or medication regimen shall comply with district policies and law on confidentiality of student education records—records that include student health records. All school employees are required, as soon as possible, to report to building administration or his/her designee any observed or reported sign or symptom that a student may be having an adverse medication reaction or allergic reaction.

Only a licensed nurse can take a verbal order from a licensed prescriber in the school setting. Except as provided in this policy for certain emergency medications (Epinephrine, Glucagon injection and Diastat gel), only a licensed nurse shall administer other injectable medications in the school setting. School staff cannot provide any parenteral medication unless they have had individualized delegation from a nurse and are on the North Dakota Board of Nursing registry. Students who require emergency epinephrine treatment in accordance with ND Administrative Code Ch. 33-37-01 and/or students who require emergency medication

under NDCC 15.1-19-16. This policy shall not supersede NDCC 15.1-19-16, which contains criteria for a school to authorize student self-administration of emergency medication. In an emergency, school personnel can administer Glucagon injection and Diastat gel according to NDCC 43-12.1-04(01).

In no case should a staff member provide, recommend, prescribe, or require medication. The building administrator of each school shall ensure that the procedural safeguards and records contained in this policy are followed prior to administration of any medication or treatment. The building administrator of each school shall designate who shall be given the responsibility to check in and administer the medication.

All personnel having responsibility for supervising students shall have access to information on the health portions of the student's school records, including related medical problems, and shall be informed of anticipated circumstances for which school personnel may need to be in touch with emergency or medical personnel.

A list of designated personnel within the school building who are responsible for administering the medication should be kept on file with the building administrator. Any violation of this policy or other district rules governing medication may result in disciplinary action, including, but not limited to, discharge (in accordance with applicable law) and/or removal of medication provider duties, if applicable.

**Types of Medication Provided**

The District may provide both prescription and over-the-counter medication to students covered by this policy so long as they are legal under state law and are authorized to be provided to the student by his/her parent/guardian and, when applicable, healthcare provider in accordance with this policy. Eligible school medication providers may provide oral and non-oral, noninvasive medication (i.e., medication provided by non-parenteral routes) to students covered by this policy. The medication must be FDA-approved. Currently, CBD oil is not FDA-approved.

Prescription and non-prescription ("over-the-counter") medications required by a student shall be administered by a parent at home or by the student's medical provider if possible. Parents shall use every effort to have medication administration times set for time periods other than school hours. When this is not possible, within the limitations set by this policy, the Fargo Public School's trained staff or school contracted nursing staff, may assist in the administration of medication during school hours. The Fargo Public Schools retains the right to refuse to administer medications or provide other medical treatments. No prescription or nonprescription medication should be carried by a student or kept in his or her locker unless the authorization for self-administration has been completed.

School personnel will administer no prescription medication unless prescribed by a licensed prescriber and have the authorization forms signed by both the parent or legal guardian and the licensed provider.

Except for students covered by an Individual Education Program (IEP) or 504 Plan, if a student's medication requires administration through the parenteral route, the District may deny a parent's/guardian's request to provide such medication or may require the parents/guardians to reimburse the District for the expense of hiring a healthcare provider who has authority under state law to administer such medication, if the District does not have a medically qualified and eligible school medication provider on staff who is willing to administer the medication. Eligible school medication providers shall not provide medication through parenteral routes unless they have the proper authority under state law, including certification or licensure, to perform such functions. The District shall retain verification of such authorization, certification, or licensure.

If a medically qualified and eligible school medication provider is requested to perform any invasive medication administration, the District first should contact its insurer to determine if additional liability

coverage is necessary if the District has not previously made this inquiry.

Prior to the administration of medication, verify the health care provider's orders with the current pharmacy labeled container for

- Right Name of student
- Right medication
- Right dosage
- Right time
- Right route (oral, topical)
- Right documentation after giving the medication

**Documentation**
A separate record for each student shall be kept of the administration of medication on a "Medication Administration Record" (AF6720-B) that includes: student name, medication, dosage, time, and signature of person administering the medication, and a place for other information to be recorded, such as any observed reaction to the medication or possible side effects. The school nurse may record the over the counter stock medication administration on the office visit documentation. All such records shall be deemed a permanent part of the student's ~~health~~ record~~s~~ and shall be confidential. Medication and treatment forms (AF6720-A, AF6720-B, AF6720-C, AF6720-D, AF6720-E1, E2, and E3, AF6720-F, AF6720-G, AF6720-H and AF 6720-I) will be scanned into PowerSchool at the end of each school year.

**Students Eligible for Participation**
The following students are eligible for participation in the medication program established by this policy:

- Students who qualify for this service under their IEP or 504 Plan. The District shall pay the cost of these services.
- Students who are not covered by the Individuals with Disabilities Education Act (IDEA) or 504 but who require medication when under the direct supervision of the school and whose parents/guardians are unable to make arrangements to provide medication themselves. An exception to such a student's participation in the medication program may apply if the student requires medication through a parenteral route (see section on routes of medication provided).

**Requirements for Parents/Guardians Prior to District Providing Medication**
Whenever possible, the first dose of medication should be given to a student at home. A parent/guardian must sign a written form authorizing his/her student to receive medication from an eligible school medication provider prior to carrying out this service. A new authorization form is required anytime the student has a change in his/her medication regimen, when a new medication is to be provided and at the beginning of each school year.

<u>For prescription drugs</u>: Any prescription medication to be administered must be accompanied by a completed "Prescription or Over the Counter Authorization for Medication Administration" form (AF6720-A) which must be signed by the student's parent or legal guardian and the student's dentist, physician, and/or other licensed prescriber. It is also acceptable to have a current computerized medication list from the health care provider. This form requires instructions from an appropriate healthcare provider on how, when, and how long to provide medication. Prescription medications must be supplied in the original pharmacy-labeled container and include the name and phone number of the pharmacy.

<u>For over-the-counter medication</u>: Any over-the-counter medication to be administered must be accompanied by a completed "Prescription or Over the Counter Authorization for Medication Administration" form (AF6720-A), including instructions from the parent/guardian on how, when, and how long to provide medication. Over-the-counter medication must be supplied in the original manufacturer's container, and the container must list the

ingredients, and storage instructions. The container must be labeled with the student's name, date of birth and if unsealed the number or amount of medication in the container. If providing from the stock supply the manufacturer recommended dosage must be followed and parental permission obtained. If the parent/guardian requests a dosage different than the manufacturer's recommendation for a non-prescription medication; a signed authorization will be necessary from both the parent/guardian and the licensed prescriber prior to giving the medication.

If dispensing equipment is required (e.g., measuring cups, droppers), it must be provided by the parent/guardian. The equipment must be clean, operable, and labeled with the student's name and date of birth. Any special medical equipment storage instructions must be provided to the school by the parent/guardian or student's healthcare provider.

The following information must be included on the "Prescription or Over the Counter Authorization for Medication Administration" form:

- Student's name and date of birth
- Name and strength of medication and route (i.e., oral, injection)
- Dosage amount
- Time of administration
- Length of time student will be on medication
- Storage instructions, such as refrigeration
- Instructions for administration
- Major side effects or adverse reactions
- Amount of medication received by school and expiration date
- Allergies

For all requests for the school to provide medication the following applies:

- Contact numbers for the student's parents/guardians and healthcare provider(s)
- Waiver of confidentiality allowing administration or the eligible school medication provider to contact the student's healthcare provider(s) with questions or concerns and allowing the District to share information about the student's health condition and/or medication regimen with any school employee/volunteer with a legitimate need to know.
- Information on possible adverse reactions and side effects associated with each medication that the parent/guardian is requesting the school to provide and certification that students have been educated in possible side effects.

All medication must be hand delivered by a parent/guardian to the designated district official. This official shall ensure that the appropriate authorization form(s) is/are complete, that the medication has not expired, that the medication is appropriately labeled in accordance with above requirements, and that parents/guardians have complied with all other applicable provisions of this policy before accepting the medication from the parent/guardian.

**Medication Check-In Requirements When District is Administering Medication**

The building administrator of the school shall designate who within the school will be given the responsibility to check in and administer the medication.

The authorized school designate will complete medication check in form. AF 6720-I and file the check in form with the Prescription or Over the Counter Authorization for Medication Authorization (AF 6720-A).

The administrator shall establish a medication check-in procedure to be done by the designated personnel or

the school nurse, to include the following:

- record the date medication was deposited;
- ensure the required authorization is on file;
- notify the person designated to administer medication;
- count and record the number or amount of medication if possible in the presence of the person who deposited the medication.

School shall accept no more than one month's supply of any prescription medication at one time. It is the parent or guardian's responsibility to replenish the medication supply if necessary.

All medication must be hand delivered by a parent/guardian to the designated district official. This official shall ensure that the appropriate authorization form(s) is/are complete, that the medication has not expired, that the medication is appropriately labeled in accordance with above requirements, and that parents/guardians have complied with all other applicable provisions of this policy before accepting the medication from the parent/guardian.

**Medication Storage and Disposal**
Medication will be stored in the following manner:

- All medications will be kept in a secure, locked, clean container or cabinet
    - Inaccessible to students
    - Separate from staff medication
    - Protected from sources of contamination
- Away from heat, light, and sources of moisture (e.g., not in the kitchen or bathroom)
    - At temperature specified on the label (refrigerated if required)
    - So that internal (oral) and external (topical) medications are separated
    - Separate from food
      • In a sanitary and orderly manner
    - Controlled substances susceptible to theft (e.g., Ritalin) will be stored in a locked container, which shall be stored in accordance with label storage instructions. Administration may consult a pharmacist for a list of such substances.

Medications that are out—of-date or for which parental/medical authorization has expired must be picked up by the parent/legal guardian. A designated school medication provider or school nurse is responsible for sending such notice to parents/guardians. The notice should contain a reasonable deadline for the parent/guardian to pick up the medication and notification that failure to pick up medication by the deadline or failure to make arrangements to pick up the medication on an alternate date after the deadline will result in the school destroying the medication. Under no circumstances will medication be released to students except medication that a student is authorized to carry. When medications are not picked up by the parent/guardian, they must be destroyed in accordance with government recommendations and that process should be witnessed and documented on form Medication Record Administration (AF 6720-B) by the building principal or designee who is not the school medication provider.

Needles and syringes must be disposed of in a manner consistent with appropriate Occupational Safety and Health administration guidelines.

Failure of a school medication provider to comply with the above storage and disposal requirements may result in the district revoking medication responsibilities and/or disciplinary action.

**Student Self-Administration Requirements**
When the student can demonstrate proper administration of the medication (such as an inhaler for asthma), and

if the student, his/her parent/guardian, health care provider and principal agree it is appropriate for the student to self-administer the medication, the student will be allowed to carry and self-administer the medication. The "Request and Authorization for Student Self-Administration of Medication" (AF6720-F) must be completed and signed by parent/guardian and the health care provider. Questions regarding any student observed by school personnel self-administering medication should be referred to the school nurse/or building principal.

A new authorization form is required anytime the student has a change in his/her medication regimen, when a new medication is to be provided, and at the beginning of each school year. This form must include the following:

**For prescription medication:**

- Authorization to self-administer medication from the student's healthcare provider. This authorization must indicate whether the student is authorized only to self-administer the medication or is authorized to carry and self-administer the medication.
- Instructions from an appropriate healthcare provider on how, when, and how long the student will need to self-administer medication.
- Certification from the healthcare provider that the student has received instruction in and is capable of self-administering the medication in a responsible and secure manner.
- For controlled substances only 2 or 3 pills can be with the student at one time.

**For over-the-counter medication:**

- Instructions from the parent/guardian on how, when, and how long the student will self-administer medication. If the student will take a dosage other than as recommended by the manufacturer, the District requires approval from an appropriate healthcare provider prior to authorizing the student to self-administer.
- Certification from the parent/guardian that the student has received instruction in and is capable of self-administering the medication in a responsible and secure manner. This certification must indicate whether the student has parental consent to self-administer the medication or has parental consent to carry and self-administer the medication.

All student self-administration of medication requests must include:

- Contact numbers for the student's parents/guardians and healthcare provider(s)
- Waiver of confidentiality allowing administration or an eligible school medication provider to contact the student's healthcare provider(s) with questions or concerns and allowing the District to share information about the student's health condition and/or medication regimen with any school employee/volunteer with a legitimate need to know.
- Acknowledgement that student has received information on possible adverse reactions and side effects associated with each medication that student will self-administer.

Students will be prohibited from carrying medication that has special storage requirements such as, but not limited to, medication that requires refrigeration. The District may require the student to comply with additional medication storage requirements for safety reasons. These requirements will be developed on a case-by-case basis.

**Self-Administration Check-In Requirements**

Before a student self-administers medication in schools, the following check-in procedures are required:

1. The building administrator of the school shall designate who within the school will be given the responsibility to check in and administer the medication.
2. The authorized school personnel will complete the medication check in form. AF 6720-I and file the check-

in form with the request and authorization for student self-administration of medication (AF6720-F).

3. The administrator shall establish a medication check-in procedure to be done by the designated personnel or the school nurse, to include the following:
   a. record the date medication was deposited;
   b. ensure the required authorization is on file;
   c. notify the person designated to administer medication;
   d. count and record the number or amount of medication if possible in the presence of the person who deposited the medication.
4. School shall accept no more than one month's supply of any prescription medication at one time. It is the parent or guardian's responsibility to replenish the medication supply if necessary.
5. If dispensing or other medical equipment is required for a student to self-administer medication (e.g., measuring cups, droppers), it must be provided by the parent/guardian. The equipment must be clean, operable, and labeled with the student's name and date of birth. Any special medical equipment storage instructions must be provided to the school.
6. Prior to a student self-administering medication, the medication must be hand delivered by a parent/guardian to the designated district official. This official shall ensure that the appropriate authorization form(s) is/are complete, that the medication has not expired, that the medication is appropriately labeled in accordance with above requirements, and that the parent/guardian and student has complied with all other applicable provisions of this policy before authorizing a student to self-administer the medication.

**Medication Off-Campus When Student is Under District Supervision**
Parents/guardians must make arrangements with the building principal for students who will require medication off-campus while under the district's supervision prior to the activity or event (e.g., students who participate in extracurricular events or field trips). At a minimum, parents/guardians making such a request shall be required to comply with the applicable authorization requirements contained in this policy. The District shall develop, on a case-by case basis, check-in and storage requirements for all medication provided or self-administered in this context. The District may consult the student's healthcare provider(s) when developing these rules.

The administration of medication on field trips and during extracurricular activities shall be as follows:

- If the student is to self-administer medication the same procedure shall be in effect as for the regular school day.
- Any medication to be administered to a student while on a field trip or during extracurricular activities will be kept in the possession of an adult assigned to administer the medication and accompanying the student on the trip.
- All medication must be clearly marked in a sealed envelope with the student's name, the medication name, and directions as to the dosage, time and method of administration. The assigned adult is responsible for recording the medication administration upon the return to school. This needs to be recorded on the individual student's medication record administration form.

**Special Treatments/Observations**
Special treatments (i.e. catheterization, chest percussion therapy, and gastrostomy feedings) are delegated medical functions. They require a licensed prescriber's written order and written parent/guardian permission and should be included in the student's Individual Education/Health Plan.  When students require extensive medical health related observations while in school or if medical-health related equipment or appliances must be monitored while the student is in school, additional procedures will need to be established. (See "Authorization for Administration of Specialized Health Care Procedures" form (AF6720-C) and "Documentation of Procedure Administration" form (AF6720-D).

If medication is administered while a treatment is being given, the requirements of the medication administration policy need to be met.

**Additional Prohibitions, Restrictions, and Requirements for Students**
All students are required to comply with the district's policy on drug and alcohol-free schools, which contains prohibitions on illegal activities associated with prescription and over-the-counter medication. Students who violate the Drug and Alcohol-Free Schools policy by engaging in a prohibited activity with medication originally authorized by this policy may be subject to disciplinary action. In addition, the District may refuse to provide medication to the violating student and/or may prohibit the violating student from self-administering medication as long as:

- The student is **not** covered by an IEP or 504 Plan.
- The medication is not covered by an emergency provision in law or needed on an emergency basis as determined by administration in consultation with the student's healthcare provider (i.e. inhaler, Epi pen or insulin). Parents/guardians of violating students not subject to an exception above will be required to make arrangements to provide medication to their children during the school day.

**Healthcare Plan for the Student with Diabetes**
Due to the complexity of diabetes and the different levels of assistance needed to manage diabetes, a Healthcare Plan (AF6720-G) can be formulated by the parent, student, teacher/principal and school nurse. The plan shall include the written signed order of the student's licensed health care prescriber, parent/guardian signature, and should identify which trained/delegated personnel can assist with the blood sugar monitoring and administration of insulin. This plan includes management related to meals and snacks, exercise and sports, blood sugar testing, low or high blood sugar readings, carbohydrate counting, and insulin administration. The documentation of blood sugars or carbohydrate counting would be recorded on the form "Documentation of Procedure Administration" (AF6720-D). The documentation of insulin administration would be recorded on "Medication Administration Record" (AF6720-B)

**Emergency Medications**
All personnel must be informed of proper procedures in emergencies and of circumstances in which they are expected to directly call the emergency medical assistance number. THE EMERGENCY NUMBER FOR FARGO IS 911.

If medication is for emergency use only, such as a bee sting kit (Epi-Pen) for known acute allergic reaction, Glucagon injection for severe hypoglycemia, and Diastat gel for seizures as per the parameters on the care plan, it may be administered by the school nurse or a person trained by the licensed school nurse or licensed health care prescriber upon written consent from a parent or legal guardian. Naloxone for opioid overdose may be administered in an emergency situation. In addition, a stock Epi Pen may be used on a person with an undiagnosed health condition for an emergency if they are exhibiting symptoms of anaphylactic reaction.

For each student whose health condition requires a prescribed emergency medication, a written "Emergency Care Plan" (AF6720-E1, E2, E3, or AF 6720 G**)** will be formulated by the parent, student, teacher and school nurse. The plan shall include the written signed order of the student's licensed health care prescriber, parent /guardian signature and should identify which trained personnel can give emergency medication to the student.

Only a licensed nurse may administer emergency medications that have the potential of dangerous side effects, that require professional assessment and judgment, or that are administered by injection unless the school personnel have had training on emergency medications as listed above.

**Use of "EPI PEN" For Allergic Emergencies**

What is the Epi Pen?

The Epi Pen ingredient is epinephrine. This is the treatment of choice for allergic emergencies (anaphylactic reactions). Epinephrine quickly constricts blood vessels, relaxes smooth muscles in the lungs to improve breathing, stimulates the heartbeat, and works to reverse hives and swelling around the face and lips.

The Epi Pen is commonly prescribed for people who have had severe allergic reactions to certain foods such as nuts, eggs, or food additives; to drugs such as penicillin; to stings by bees, wasps, hornets, or other allergens.

When do I give it?

Allergic reactions can occur in seconds or minutes after exposure to the substance. The person with an allergic reaction may complain of dizziness, faintness, hives, flushing of the face, itching, swelling of the face, tongue and/or lips. Use the Epi Pen when the person complains of tightness or pain in the chest, difficult swallowing and/or breathing.

If you're not sure, but individual does seem uncomfortable or in distress -- give it. It is safer to do this than to wait.

How do I give it?

Remove the gray or blue safety cap. Hold the Epi Pen with the black or orange tip against the thigh, and apply moderate pressure for three (3) seconds. Pushing the Epi Pen against the thigh releases a spring-activated plunger, pushing the concealed needle into the thigh muscle and delivering a dose of epinephrine. Do not give into a vein or into the buttocks. If accidental injection into hands or feet occurs, go immediately to nearest emergency department. Epi Pen should only be given into the front side area of the thigh. Massage the site after injection to prevent tissue damage. If necessary Epi Pen can be used directly through clothing.

Then what?

Get medical help immediately - 911. Stay with the person, keep them warm and resting. The effects of the injection wear off after 10 - 20 minutes. Symptoms can recur. Notify parents/guardian of the reaction and the student's condition. After the injection, person may feel a more rapid heartbeat, nervousness, and headache. Stay with the student until emergency medical help arrives. Send Epi Pen with them so the physician will know the dosage given. Record incident on individual student's health card.

What else should I know?

Epi Pen cannot be reused.
Epi Pen comes in two strengths:
  0.3 mgm for adults
  0.15 mgm for young children
Check expiration date on package.
Store at room temperature - do not refrigerate.
If solution appears brown, replace the unit.
Keep the solution in light-resistant container, and don't remove before use.

**Use of Naloxone for Opioid Overdose Emergencies**

What is Naloxone?

Naloxone (Narcan) is indicated for the reversal of opioid overdose induced by natural or synthetic opioids in the setting of respiratory depression or unresponsiveness.

When do I give it?

When you find someone who appears to have an opioid overdose, naloxone (Narcan) should be administered. You cannot harm someone by doing so. In many cases, you can save their life. Signs of an opioid overdose include:

- Slow or shallow breathing
- Gasping for air when sleeping
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (sternal rub)
- Small pupils

How do I give it?

1. Initial
   - Assess scene – make sure you are safe
   - Attempt to wake the person by yelling or shaking them
   - Call 911
   - Put on gloves
   - Position to keep airway open and if indicated, initiate rescue breathing
   - If shallow breathing or not responding, provide 2 rescue breaths using mask or rescue breathing aid – you don't know how long they have been laying there

2. Rescue Breaths
   - One hand on chin, pulling chin forward and opening mouth, tilt head back, pinch nose closed
   - Make seal over mouth, breathe into mouth
   - 1 breath every 5 seconds
   - Chest should rise, not stomach (if stomach rises, readjust)

3. Administration – once you have naloxone (Narcan) and opioid overdose is suspected, with respiratory suppression or unresponsiveness:
   - If practical, activate emergency medical services
   - Remove Narcan Nasal Spray from blister package
   - Tilt person's head back and support neck. Insert tip of nozzle into one nostril. Push the plunger firmly to give dose. Remove device from nose after giving dose.
   - If needed continue rescue breathing and monitor respiration and responsiveness of naloxone recipient.
   - If no response after 2 to 3 minutes, administer another dose of Narcan Nasal Spray into other nostril.
   - Stay with the person and cooperate with responding emergency personnel.

What else I should know?

Naloxone (Narcan) has no adverse effects and will only reverse an opioid overdose.

**Opioid Antagonist Use**

According to ND Law, any individual (family, friends, community member) is protected from civil or criminal liability for giving naloxone for a suspected opioid overdose.
North Dakota Century Code 23-01-42

**The ND Good Samaritan Law was passed to encourage friends, family members, and bystanders to call 911 in the event of an overdose.**

In order to be immune from prosecution, you need to:

1. Seek emergency help – Call 911
2. Remain onsite until assistance arrives

3. Cooperate with responding personnel giving emergency medical treatment

The Law provides protection from prosecution for the individual experiencing a drug-related overdose and those seeking the emergency medical assistance.
North Dakota Century Code 19-03.1-23.4

**Liability Disclaimer**

It is not the intent of the District to expand or modify the district's potential liability exposure through the development of this medication program. The district's voluntary creation of this program shall not be construed to create or assume any potential liability under any local, state, or federal law or regulation. State law provides liability protection for establishing and providing medication under a school medication program. This protection extends to all eligible school medication providers, the school district, and the Board so long as each party is acting in good faith.

The District is not responsible for determining the qualifications of healthcare providers whose signatures appear on prescriptions and other medical documentation submitted to the District by parents/guardians. The District assumes that by signing such documentation, the healthcare provider is attesting to the validity of his/her qualifications and credentials. The District will comply with healthcare providers' orders but assumes no liability for their content.

**School Medication Program Regulations Authorizing Participation**

The District shall designate at least one eligible school medication provider to receive all requests to participate in the school medication program. This individual(s) shall be responsible for ensuring that parents/guardians and students are in compliance with all applicable components of the district's policy and law on the school medication program before authorizing participation. This includes, but is not limited to:

- Completion by the parent/guardian, healthcare provider (if applicable), and student of the Authorization/Parental Consent for School to Provide Medication or Student to Self-Administer Medication form
- Verification that parent/guardian has satisfied all check-in requirements.
- Compliance with NDCC 15.1-19-16, if the student will self-administer emergency medication covered by this law.

The authorizing school medication provider(s) may defer any request to provide medication should such request be incomplete or otherwise noncompliant with district policy or law. The authorizing school medication provider(s) may deny a request to provide medication prohibited by district policy. The authorizing school medication provider(s) may also deny a request to provide medication through a parenteral route except when:

- The student is required to receive the medication under an IEP or 504 Plan.
- The school has a medically qualified and eligible medication provider who has agreed to provide the medication.

The authorizing school medication provider(s) shall consult with administration prior to acting on any request to provide medication through a parenteral route.

**Requirements for Providing Medication**

All school medication providers are required to provide medication in good faith consistent with medication training and education received, including compliance with all training and education in medication safety, handling and dispensing, student identification, documentation, and sanitation protocols. All school medication providers are required to document all medication provided on the Medication Record Administration form. Failure to complete this documentation may result in the District revoking medication responsibilities.

**Medication Incidents or Errors**
Medication providers are required to complete a Medication Incident Report (AF 6720-J) for any medication incident or error, including but not limited to:

- Forgot to document the medication by the end of school day on which the medication was provided
- Forgot to give a dose of medication
- Gave the medication at the wrong time
- Gave the medication by the wrong route
- Gave the wrong dose of the medication
- Gave the wrong medication
- Gave the medication to the wrong child
- Student refused a dose of medication

The form is to be completed as soon as possible after the incident occurred and appropriate response actions/interventions were taken. It must be filed with the building principal. Failure to complete this documentation may result in the District revoking medication responsibilities.

**Program Review**
The District may require medication providers to undergo additional training as needed and may hire a qualified consultant to audit the school medication program periodically.

1977
Revised 5/2003
Revised 4/2009
Revised 12/2009
Revised 6/2010
Revised 4/2014
Revised 9/2016
Revised 11/2017
Revised 7/2022

# FARGO PUBLIC SCHOOLS
# PRESCRIPTION OR OVER THE COUNTER (OTC) AUTHORIZATION FOR MEDICATION ADMINISTRATION

When it is determined by the physician that medication must be taken during the school hours this form is to be completed.

Student__________________________________________ Date________________________________

Grade_____________ Date of Birth____________________ School______________________________

Allergies________________________________________ School Year________________________________

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**PHYSICIAN'S ORDER or Clinic to provide a current computerized medication list to the school.**

Medication__________________________________ Dose_____________ Route_________________________

Time /Frequency_____________________________ Continue Until______________________________

Reason for Medication/Diagnosis_____________________________________________________________

Special Instructions______________________________________________________________________

Major Side Effects/Reactions________________________________________________________________

Action/treatment for side effects____________________________________________________________

Special handling instructions Refrigeration Keep out of sunlight Other ______________________

Date_____________________ Physician Name (Print) __________________________________________

Physician Signature*______________________________________________________________________

Phone__________________________ Address______________________________________________

*Physician signature on OTC medications is required only if dosage is not within the manufacturer's recommended guidelines.

---

Amount of Medication Received ____________ Medication Expiration Date______________________

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications. Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization. I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's health record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

Date_____________________ Parent /Guardian___________________________________________________

Phone (H)______________________ Address_______________________________________________

(C)______________________ (W)_____________________________

Alternate family member's emergency contact name and number ______________________________

________________________________________ Home Work Cell

7/2022

## MEDICATION RECORD ADMINISTRATION

AF6720-B

SCHOOL YEAR_________________ SCHOOL_________________________

STUDENT NAME__________________________ DOB___/___/___ GRADE_______ TEACHER_______________________

MEDICATION / PROCEDURE__________________________________ DOSE________________ TIME______________________

FROM:_______________________________________20______ TO:____________________________________20______

See "PRESCRIPTION & AUTHORIZATION FOR MEDICATION ADMINISTRATION" or "AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES." Attach this to that appropriate form for instruction and reference.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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| AUGUST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SEPTEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCTOBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOVEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DECEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JANUARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEBRUARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARCH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APRIL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JUNE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

*** See Comments on Back Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed Ho=Holiday Ft=Field Trip OOM=Out of Medication Ed=Early Dismissal**

| INITIALS | NAME | INITIALS | NAME |
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| DATE | COMMENTS | DATE | COMMENTS |
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# AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES

Students who need specialized health care procedures provided during the school day must have, in writing, a physician's prescription and parental authorization.

Student_______________________________________________ Date__________________

Grade__________ Date of Birth_______________ School_______________________

Diagnosis/Condition for Which Procedure Is Required_________________________________

_____________________________________________________________________

Treatment Prescription_______________________________________________

Procedure/Treatment Description______________________________________________

_____________________________________________________________________

_____________________________________________________________________

Time Schedule Procedure Is To Be Done_________________________________________

Precautions &/or Adverse Reactions___________________________________________

_____________________________________________________________________

_____________________________________________________________________

Interventions for Reactions_________________________________________________

_____________________________________________________________________

Continue Procedure Until (Date)__________________

Authorization For This Procedure Is Required Annually.

Physician Name (Print)____________________________ Date____________________

Physician Signature___________________________________Phone ______________

Address______________________________________________________________

---

I request the above health procedure and/or medication be given to my child in the manner specified herein. I give permission to school personnel to administer the health procedure and/or medication. I understand that the administration of the health procedure and/or medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this health procedure and/or medication. I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of health procedures and/or medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described health procedures and/or medications.

Parent__________________________________________ Date____________________

Address_________________________________________ Phone______________(H)

____________________(C)______________ (W)

7/2022

# DOCUMENTATION OF PROCEDURE ADMINISTRATION

Student_________________________________ DOB__________________ Grade______

School_______________________ Teacher_______________________________________

Medication/Procedure__________________________________ Dose__________________

From______________________________20___ To______________________________ 20___

See "PRESCRIPTION OR OVER THE COUNTER & AUTHORIZATION FOR MEDICATION ADMINISTRATION" or "AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES". Attach this to that appropriate form for instruction and reference.

| Date | Time In /Out | Comments | Initials |
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Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed

Signatures__________________________ ______________________ ______________________

______________________ ________________ ______________________ ________________

7/2022

# EMERGENCY CARE PLAN

**Student**__________________________________________________ **Date**__________________

**Grade**______ **Date of Birth**_________________**School**_______________________________________

**Parent/Guardian**_____________________________________**Phone**_______________________(H)

_______________________________(C) _______________________(W)

**Preferred Hospital In Case Of Emergency**________________________________________________

**Physician Name (Print)**_______________________________________________________________

**Physician Signature**_____________________________________________**Phone**__________________

---

**Medical Condition**______________________________________________________________

**Non-Emergency Routine Treatment**_______________________________________________________

__________________________________________________________________________________

_________________________________________________________________

**Signs /Symptoms of Emergency**___________________________________________________________

_______________________________________________________________________

**Emergency Treatment**_________________________________________________________________

__________________________________________________________________________________

_________________________________________________________________

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I give permission to the principal and to the school nurse to share this “Emergency Care Plan” with the school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above “Emergency Care Plan” and request school personnel to follow the above “Emergency Care Plan” in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this “Emergency Care Plan.” I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above “Emergency Care Plan” from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above “Emergency Care Plan.”

**PARENT SIGNATURE**_____________________________________________**DATE**__________________

# EMERGENCY CARE PLAN FOR ASTHMA

**Student**______________________________ **Date**__________

**Grade**________ **Date of Birth**____________ **School**____________________

**Parent/Guardian**____________________ **Phone**______________(H)

____________________(C) ______________(W)

**Preferred Hospital In Case Of Emergency**______________________________

**Physician Name (Print)**______________________________

**Physician Signature**______________________________ **Phone**__________

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**Medical Condition**________Asthma________________ **Allergies**__________

**Non-Emergency Routine Treatment**______________________________

______________________________

Will the student need a rescue inhaler at school? ☐ Yes ☐ No

Where will the rescue inhaler be kept? ☐ On student (pocket, binder, purse) ☐ In Nurse's office

(Check all that apply) ☐ Locker ☐ Gym Locker

**Usual Triggers**______________________________

______________________________

**Signs /Symptoms of Emergency**______________________________

______________________________

______________________________

**Emergency Treatment**______________________________

______________________________

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I give permission to the principal and to the school nurse to share this "Emergency Care Plan" with school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above "Emergency Care Plan" and request school personnel to follow the above "Emergency Care Plan" in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this "Emergency Care Plan." I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above "Emergency Care Plan" from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above "Emergency Care Plan."

**Parent Signature** **Date**

AF6720-E3

# EMERGENCY CARE PLAN FOR SEIZURES

**Student**________________________________________________ **Date**________________________

**Grade**____________ **Date of Birth**__________________**School**____________________________________

**Parent/Guardian**______________________________________**Phone**________________________(H)

___________________________________(C) ________________________(W)

**Preferred Hospital in Case of Emergency**___________________________________________________

**Physician Name (Print)**___________________________________________________________________

**Physician Signature**_____________________________________________**Phone**________________________

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**Medical Condition** __SEIZURES_________ **Type**____________________**Average Length**__________

**Non-Emergency Routine Treatment (Routine Daily Medication)** _____________________________________

**Triggers or Warning Signs**_________________________________________________________________

__________________________________________________________________________

**Signs/Symptoms of Emergency**_____________________________________________________________

________________________________________________________________________________

**First Aid During Seizure**

- Do not restrain
- Turn child on side
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure activity
- Record start/end time

☐ Other____________________________________________________________________________

**Emergency Treatment Call 911 if seizure** lasts longer than ____________ minutes

Notify parent if_________________________________________________________________________

---

I give permission to the principal and to the school nurse to share this “Emergency Care Plan” with school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above “Emergency Care Plan” and request school personnel to follow the above “Emergency Care Plan” in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this” Emergency Care Plan”. I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above” Emergency Care Plan” from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above “Emergency Care Plan”.

**PARENT SIGNATURE**_______________________________________________**DATE**___________________

7/2022

# REQUEST AND AUTHORIZATION
# FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student______________________________ Date ______________________________

Grade__________ Date of Birth______________ School ______________________________

Allergies______________________________ School Year______________________________

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## PHYSICIAN'S ACKNOWLEDGEMENT OF PRESCRIPTION OR OVER THE COUNTER

Medication________________________ Dose______________ Route______________
Time /Frequency______________________________ Continue Until__________________

I have reviewed the medication with the student and the student's parents, and the medication may be self- administered by the student during school hours.

Date______________ Physician Name (Print) ______________________________
Physician Signature ____________________________________________
Phone__________ Address____________________________________________

---

The student is capable of self administering this medication in a secure manner No Yes supervised Yes unsupervised
This student may carry this medication Yes No (kept in Nurse Office)

The undersigned, as parent(s)/guardian of the above named student, request permission for, and hereby authorize, the student to self-administer the above named medication during school hours. Further, the undersigned acknowledge and understand the following:

1. Medication shall be maintained in the original prescription container with original label;
2. School personnel may examine the medication container upon request, and any medications not maintained in the original container may be confiscated by school personnel;
3. The school may require the student to store the medication in a central location in the school;
4. The undersigned has reviewed the medication administration procedure with the student and believe student understands the administration procedure and is capable of self-administering the above medication;
5. The undersigned will notify the school immediately if the student's health status changes, or there is a change or cancellation of this medication;
6. School employees and personnel will not be involved in the administration of the above medication and will not be monitoring the student for side effects or student's failure to take the medication. The undersigned and student shall be solely responsible to assure that the medication is taken as prescribed.
7. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.
8. This student has received instruction in self administering the medication in a secure manner. In addition, the student has received education on any side effects or adverse interactions associated with the medication and how to prevent them.
9. For any controlled medication that the student will self administers only 2 or 3 pills can be in their possession at one time.

In consideration of this authorization, given at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees of the School and Board of Education from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Date______________ Parent/Guardian____________________________________________

Phone (H)__________ Address____________________________________________

(W)________________________ (C )__________________

7/2022

## EMERGENCY CARE PLAN FOR DIABETES

**Student**______________________________________________ **Date**______________________
**Grade**_______ **Date of Birth**_______________________**School**________________________________
**Parent/Guardian**______________________________**Phone**_____________________________(H)
______________________________(C) _____________________________(W)
**Preferred Hospital In Case of Emergency**_______________________________________________
**Physician Name (Print)**___________________________________________________________
**Physician Signature**___________________________________________**Phone**_________________

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### BLOOD SUGAR TESTING

Will student need assistance to check blood sugar? ☐ Yes ☐ No

Daily Testing Times at School ___________ ___________ ___________ ___________

Method used: Type of meter_________________________________________

Test Strip required_____________________________________

Testing site: (classroom or nurse office)_______________________________

Testing supplies (kit, sharps container, record) will be stored_________________

What is this student's target range for blood sugar reading? ___________mg/dl to___________mg/dl

### INSULIN ADMINISTRATION

**Physician direction for sliding scale (correction dose) for high blood sugar and/or carbohydrate intake: (To be completed only by health care provider)**

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

- **Type** of insulin ______________________________________________________________
- **Method** of insulin administration (i.e. pen, pump, syringe)______________________________
- Insulin and supplies will be stored__________________________________________________
- Will student need assistance in giving their own insulin? ☐ Yes ☐ No

### TRAINED PERSONNEL

- Name of staff person(s) authorized and trained/delegated to assist student :
- #1____________________________☐ blood sugar test ☐ insulin injection available in room #_____
- #2____________________________☐ blood sugar test ☐ insulin injection available in room #_____
- #3____________________________☐ blood sugar test ☐ insulin injection available in room #_____

The designated personnel have been trained/supervised in monitoring blood sugars and insulin administration by : ______________________________________________Date____________________

## LOW BLOOD SUGAR (HYPOGLYCEMIA)

**Causes**
Too much insulin in the body
Less food than usual
Increase in exercise, physical activity

**Symptoms** (Circle all that apply to student)

| | | |
|---|---|---|
| Sweaty | Shakiness / trembling | Dizziness |
| Hungry | Irritability | Weak/Poor Coordination |
| Tired | Headache | Other ___________________ |
| Personality change | Inability to concentrate | ________________________ |

- **A low blood sugar usually requires immediate care**.
- Many times students will be aware that their blood sugar is low, but this can occur with little warning. The only way to know is to test their blood sugar.
- Frequently a low blood sugar can occur before lunch or after strenuous exercise.
- The student **must be accompanied** to the testing site (i.*e.* nurse office, main office) if not feeling well.
- The student may need a rest period of ___________ minutes to recover before participating in activity.

**Treatment**

1. **Give** the student ________________________________________________________ if their blood sugar is less than _______ and/or is having symptoms of low blood sugar.
2. **Repeat** treatment if symptoms do not improve in 15-20 minutes. Call parent? ☐ Yes ☐ No
3. **Give** a snack of ________________________________ after symptoms subside to prevent recurrence of low blood sugar episode prior to the next meal/snack.
4. Repeat the blood sugar test? ☐ Yes ☐ No
5. **Call 911 IMMEDIATELY** if student does not respond, is not able to eat or drink, begins to lose consciousness or has a seizure. Also call parents and school nurse. Never give fluids or solid food as the student could choke on this.
6. **Whenever in doubt CALL 911.**
7. **Note:** The student may return to class as soon as he/she is mentally alert and all symptoms have subsided. It may take 20 minutes to recover, however they may not be ready for taking a test or performing at usual ability. Concentration and memory may be compromised.

## HIGH BLOOD SUGAR (HYPERGLYCEMIA)

**Causes**
Not enough or forgotten insulin
Too much food / wrong type of food
Illness, infection, stress
Decrease in usual activity

**Symptoms** (Circle all that apply to student)

| | | |
|---|---|---|
| Excessive thirst | Stomach ache | Dry Skin |
| Frequent urination | Nausea/vomiting | Blurry Vision |
| Fruity odor on the breath | Fatigue | Other_________________________ |

- **A high blood sugar does not need urgent care unless the child is ill.**
- It is good for a person to drink plenty of water if their blood sugar is high.
- Sometimes it is hard to know if a child has high or low blood sugar; the only way to know for sure is to test.
- The student may need rest period of _____________ minutes to recover before participating in activity.

**Treatment**

1. **Test** the student's blood sugar. Based on blood sugar reading, the student may require additional insulin according to physician direction.
2. **Provide water** or sugar-free drinks and unrestricted access to restroom.
3. **Call parent** or emergency contact if student has above symptoms.
4. **Call 911** if parent or emergency contact is unavailable and the student is vomiting, lethargic, or too ill to remain in school.

## MEALS AND SNACKS

**Parent must be notified** before student travels outside of the school building so they can plan for this.

Morning snack time_____________________________________

Lunch time___________________________________________

Afternoon snack time___________________________________

This student will need to be reminded to take his / her snack: ☐ Yes ☐ No

Fast carbohydrate (i.e. juice, glucose tablets, regular soda) should be readily available at all times should low blood sugar symptoms occur. Student's preferred fast-acting food is_____________ ______________________________ and will be kept________________________

## EXERCISE AND SPORTS

PE teachers and coaches should be familiar with the symptoms and treatment of low blood sugar.

Any activity restrictions? ☐ No ☐ Yes _________________________

Regularly scheduled activities (i.e. PE, recess, band, other)

Activity_________________________ Time________________

Activity_________________________ Time________________

- Student should **NOT** exercise if blood sugar is below__________ or above _________mg/dl.

**NOTE: Parents/guardians and student are responsible for maintaining necessary supplies, snacks, testing kit, medications, and equipment at school.**

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I give permission to the principal and to the school nurse to share this "Emergency Care Plan" with school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above "Emergency Care Plan" and request school personnel to follow the above "Emergency Care Plan" in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this "Emergency Care Plan". I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above "Emergency Care Plan" from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above "Emergency Care Plan".

**Parent Signature** **Date**

**FARGO PUBLIC SCHOOLS**
**SCHOOL MEDICATION PROVIDER OPT-OUT OR OPT-IN**
**AND VERIFICATION OF ELIGIBILITY FORM**

***INSTRUCTIONS:*** *Initial the option that applies.*

☐ **OPTION ONE: OPT-OUT**

I choose to opt-out of providing medication to students for the 20___-___ school year. I understand that I am prohibited from providing students any type of medication, whether prescription or over-the-counter, whenever serving in my official capacity for the school, and I may be subject to disciplinary action for violating this prohibition. I also understand that if I wish to retract this opt-out request, I must first meet the district's qualification standards for eligible medication providers, which include education and training in providing medication, receive authorization from my building principal and receive parental consent. _____ (initials)

☐ **OPTION TWO: OPT -IN AND VERIFICATION OF ELIGIBILITY**

I agree to serve as a school medication provider for the Fargo Public School for the school year 20___-___. I have completed the required education and training to perform this responsibility (attach proof of completion), including education and training in the following areas:

a. The scope of my authority and my role in providing medication
b. Proper medication storage, inventory, and disposal
c. Proper techniques for providing medication including, but not limited to, understanding pharmacy labels, standard precautions for infection control (e.g., hand washing), six rights of medication administration, and measuring and dispensing protocols
d. Appropriate documentation of all medication provided and confidentiality requirements
e. Basic medical terminology related to providing medication
f. Appropriate action if unusual circumstances occur (e.g., medication error, adverse reactions, student refusal) and how and when to seek medical consultation or assistance

I agree to provide medication in accordance with district policy and regulations only after I have received authorization from my building principal and parental consent.___ (initials)

Employee name ________________________________

Employee signature ________________________________Date ____________________

Building Principal signature _________________________Date ____________________

TO BE COMPLETED BY SCHOOL AUTHORITY

Date form received by building principal ____________________________________

Date of last criminal history record check: ___________________________________

Employee received satisfactory adjudication on criminal history record check for purposes of providing medication? Circle Yes No

Employee eligible to serve as school medication provider circle Yes No

Human Resources signature _________________________Date ____________________

**MEDICATION CHECK-IN FORM** **AF 6720-I**

*NOTE: To be completed by an eligible school medication provider prior to accepting medication from parent/guardian or authorizing a student to self-administer. If the answer to any question is "no," the district may defer the medication request until the parent/guardian provides the required information.*

**Medication was hand delivered by parent/guardian:** ☐ Yes ☐ No *If no, collect medication, store as directed, and contact parent/guardian to come to school as soon as possible to verify medication request.*

- Parent submitted **fully** completed authorization form: ☐ Yes ☐ No
- If request is to provide/authorize over-the-counter medication in manner other than recommended by manufacturer, authorization from healthcare provider is included: ☐Yes ☐ No ☐ N/A
- Includes healthcare provider's signature for prescription medication: ☐ Yes ☐ No ☐N/A

Name of medication:______________________________ ☐ Prescription ☐ Over-the-counter

Name of student:________________________________________ Date of Birth:___________________

Who is requested to provide medication? ☐ School personnel ☐ Student under supervision ☐ Student without supervision
☐ Check here if request is for student to carry the medication.

Route by which medication must be given: ☐ Mouth ☐ Eyes ☐ Ear ☐ Nose ☐ Topical (e.g., skin ointment)
☐ Other:____________________________________________________________________

*NOTE: If other, check with school administrator to determine if school is obligated/willing and has qualified personnel to provide medication. This provision is not applicable if request is for student to self-administer.*

Medication expiration date:______________Was this listed on the medication container? ☐ Yes ☐ No

Amount of medication in container:________________________________

| **For prescription medication:** | **Yes** | **No** | | **Yes** | **No** |
|---|---|---|---|---|---|
| Medication in original pharmacy container | | | Container lists storage instructions | | |
| Container lists amount of medication dispensed | | | Container is labeled with student's name and date of birth | | |
| Container lists dosage | | | Container lists pharmacy name and phone number | | |
| Container lists administration instructions | | | | | |
| **For over- the-counter medication:** | **Yes** | **No** | | **Yes** | **No** |
| Medication in original manufacturer's container | | | Container lists storage instructions | | |
| If container is unsealed, it is labeled with amount of medication contained in it | | | Container lists medication's name | | |
| Container lists recommended dosage | | | Container lists ingredients | | |
| Container lists administration instructions | | | Container is labeled with student's name and date of birth | | |
| **If dispensing equipment is required:** | **Yes** | **No** | | **Yes** | **No** |
| Did parent/guardian provide necessary equipment? | | | Is the dispensing equipment clean and in good working order? | | |
| Is the equipment labeled with the student's name and date of birth? | | | | | |
| List any storage instructions for dispensing equipment: | | | | | |

| | | |
|---|---|---|
| **Name of School Medication Provider (Printed)** | **Signature of School Medication Provider** | **Date** |

**AF 6720-J**

## MEDICATION INCIDENT REPORT

**Instructions:** *To be completed as soon as possible after the incident occurred and appropriate response actions/interventions were taken. File form with the building principal.*

Date of Report:______________________________________________
Name of person completing this report:______________________________
Student's name:______________________________________________
Date of birth:____________________ Grade:_______________
Date incident occurred:______________ Time:________ ☐am ☐pm
Person providing medication:_______________________________________
Name of medication:__________________________________________
Regular dose:_____________ Regularly scheduled time:______________

### TYPE OF INCIDENT

☐ Forgot to document the medication by the end of school day on which the medication was provided
☐ Forgot to give a dose of medication
☐ Gave the medication at the wrong time
☐ Gave the medication by the wrong route
☐ Gave the wrong dose of the medication
☐ Gave the wrong medication
☐ Gave the medication to the wrong child
☐ Student refused a dose of medication
☐ Other:_______________________________________________

Provide a summary of the incident and describe how it occurred:________________
______________________________________________________________

### ACTION TAKEN/INTERVENTION

School nurse or principal notified: ☐Yes Date:________Time:_____ ☐No ☐N/A
Parent/Guardian notified: ☐Yes Date:_________ Time:________ ☐No
If yes, name of the parent/guardian who was notified:________________________
Student's emergency contact alternate notified: ☐Yes Date:________ Time:_____ ☐No
If yes, name of the emergency contact who was notified:______________________
911 Called: ☐Yes ☐No
Student's healthcare provider contacted: ☐Yes Date:________ Time:_____ ☐No
If yes, student healthcare provider's name:______________________________
Describe interventions taken and outcome:_______________________________
______________________________________________________________

### FOLLOW-UP AND PREVENTION (To be completed by building principal)

List any follow-up information related to the incident and prevention measures enacted to prevent similar incidents in the future:

______________________________________________________________
______________________________________________________________

Building administrator's signature:________________________________
Date:____________________