
Note: Additional information and procedures related to the administration of medication, emergency care, and first aid can be found in Modules 5 and 9 of the Texas Department of State Health Services' *Texas Guide to School Health Programs* at https://www.dshs.state.tx.us/schoolhealth/pgtoc.shtm.

Guidelines and protocols related to athletic trainers can be found on the Texas Department of State Health Services' *Advisory Board of Athletic Trainers* website at http://www.dshs.state.tx.us/at/.

INJURY OR ILLNESS AT SCHOOL

A student who is injured or becomes ill at school or at a school activity will be evaluated, and the student's parent will be notified if appropriate. If the parent cannot be reached, the parent's instructions on the Authorization to Secure Emergency Medical Treatment of a Student [see FFAC(EXHIBIT)–B] will be followed if necessary.

ADMINISTERING MEDICATION

Administration of medication to students will be strictly governed by FFAC(LEGAL), FFAC(LOCAL), FFAF(LEGAL), FFAF(LOCAL), any related procedures, and the following:

1. Only school administrators may assign to District employees the task of administering medication by any mode, including injectable medication, oral medication, inhalants, topical medication, or rectally administered medication. Only authorized District employees may administer medication to students. School nurses may not delegate but will oversee administration of medication when on duty.

2. District employees authorized to administer medication will be provided orientation, instruction, and supervised practice appropriate to the task [see FFAC (EXHIBIT)–D].

3. Medication for a specific student will be provided and brought to school personnel by the parent of the student. Students will not carry medication or administer it to themselves on school property or on school trips unless authorized by their physician and permitted by state law. [See FFAC(EXHIBIT)–C and FFAF] No medication will be administered to students unless provided by parent or guardian and accompanied by permission form.

4. The principal or designee will appoint one employee, such as the school nurse, to supervise the storing and administering of medications and to maintain records of the administration of medication. Any District employee administering medication to a student must record each dose given on the MISD Medication Administration Log form on in the EHR (Electronic Health Record). Records will include the parent's written request and the MISD Medication Administration Log [see FFAC(EXHIBIT)–A].

5. The principal will provide locked storage space where all medication may be maintained apart from office supplies, and it will be accessible only to authorized employees.

6. Each student's medication will have a label including the student's name, the name of the medication, directions concerning dosage, and the schedule for administration. Medications must be in original container. Any over the counter medications will be given per manufacturer's instruction unless accompanied by a physician order.

7. All requests for the District to administer medication will be reviewed at the beginning of each school year. Renewed, written permission for treatment will be required from both the physician (when necessary) and the parent. For school trips, parents must provide new permission forms and supply medication for each trip.

FFAC Regulation

8. Hypodermic injections may be administered by a registered nurse, if available, when the parental request also includes the prescribing physician's request. The physician's request must include detailed information concerning the administration of the medication, as well as follow-up procedures. The student's parent will be instructed to furnish sterile, disposable syringes and needles. Used syringes and needles will be disposed of in accordance with rules of disposal of sharp instruments.

9. When the course of treatment is complete, or at the end of the school year, the parent will be asked to pick up any medication within a specified amount of time. The District will dispose of any unclaimed medication per FDA recommendations (see link below).

   http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm

CHAIN OF CUSTODY FOR STUDENT MEDICATIONS

When medications must accompany student to or from any alternative education campus, the Authorization for Releasing Medication to MISD Employee form [see FFAC (EXHIBIT) - F] must be completed and signed. Medications may only be released to MISD employees or parent/guardian of student.

For all controlled substances, a pill count or volume verification (for liquids) will be per formed when releasing medications and upon returning medications.

GUIDELINES FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

MISD Board Policy FFAC (LEGAL) and (LOCAL) addresses issues related to the administration of medication. The Board has delegated the Superintendent or designee to administer medication and for the administration to establish procedures to ensure medication is distributed appropriately. The Board Policy and Administrative Regulations at FFAC further provide information related to the requirements and procedures for medications to be administered by school personnel.

PRIOR TO ADMINISTERING ANY MEDICATION, ALL SCHOOL PERSONNEL WILL CHECK THE RIGHTS OF MEDICATION ADMINISTRATION:

THE 7 RIGHTS OF MEDICATION ADMINISTRATION

1. RIGHT STUDENT	Properly identifies the student by asking them to state their name or, if non-verbal, verify identification with another staff member
2. RIGHT MEDICATION	Administers the right medication
3. RIGHT DOSE	Administers the right amount of medication
4. RIGHT TIME	Administers at the correct time (within 30 minutes on either side of scheduled dose)
5. RIGHT ROUTE	Administers using the prescribed method of medication administration
6. RIGHT OF REFUSAL	Calls parent and confirms if student refuses or questions
7. RIGHT DOCUMENTATION	Documents administration on student's individual medication form, or in the EHR

FFAC Regulations

FFAC Regulation

The guidelines for administering medications to students are as follows:

1. Verify completed parent authorization to administer medication to individual student (Medication Permission Form) [see FFAC(EXHIBIT)–A],is current.

2. Be sure that medication is in its original labeled container and that instructions regarding name and dosage of medication and frequency of administration are clear and legible on permission form.

3. Label non-prescription medicine container with student name and dosage. Follow label instructions for non-prescription medicines.

4. Check label for name, dosage, time and route when picking up medication bottle.

5. Prepare correct dosage of medication by pouring into lid cap or into medicine cup if liquid.

6. Recheck name, dosage, time and route when preparing dose for student.

7. Recheck label a third time when returning medicine to container.

8. **DO NOT LEAVE MEDICATION UNATTENDED AT ANY TIME.** All medication must be kept in a **locked** container at all times.

9. Identify student by asking student to say his name or verify identity with third party if student is non- verbal.

10. Administer correct medicine to correct student at correct time, using the correct dose and correct administration route.

11. Observe student placing medicine in his/her mouth and swallowing.

12. Observe student for any adverse reactions or unusual behaviors both before and after giving medication and record. Notify parent with any adverse reactions or concerns.

13. Record medication dose, date and time of administration and your signature and initials on individual student medication administration log form [see FFAC(EXHIBIT)–A], or in the EHR.

14. Report any medication errors or omissions immediately. A medication incident report form [see FFAC(EXHIBIT)– E] must be completed and filed with Health Services Supervisor.

15. Students with permission on file for self- administration of asthma, anaphylaxis or diabetes medications may self- administer their prescribed medications as ordered by their physician.

16. District employees are required to treat all records regarding medication and health-related conditions confidential. **Parent volunteers may NOT administer medications to students nor oversee medication management at any time.**

FFAC Regulation

17. During the school day, all medication is administered by the school nurse or trained principal designee.

Errors in recording should be easily visible. Use red ink and clearly mark as an error. Record omissions, student absences, or student refusals immediately. Record only medication that you have, in fact, administered.

Auto-injector medications used for anaphylactic emergencies have specific directions for administration on the medication packaging itself, and those directions should be followed.

Always activate 911 immediately when Epinephrine, Diastat, or Glucagon is administered and follow the emergency procedures outlined on the student's emergency care plan.

FFAC Regulation

See the following forms regarding administering medication and emergency health care to students:

Exhibit A:	Medication Administration Log (Request for the Administration of Medications at School) – 2 pages
Exhibit B:	Authorization to Secure Emergency Medical Treatment of a Student -- 2 pages
Exhibit C:	Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication — 2 page
Exhibit D:	Training Documentation for medication administration by administrator assigned personnel other than school nurse.
Exhibit E	Medication Incident Report Form
Exhibit F	Authorization to Release Medication to MISD Employee

Note: Sample medication logs can be found in Chapter 5 of the Texas Department of State Health Services' *Texas Guide to School Health Programs* at http://www.dshs.state.tx.us/schoolhealth/shpguide/chap5.pdf.

EXHIBIT A

MEDICATION PERMISSION FORM

Dear Parent/Guardian,

According to Texas State law and Midland Independent School District policy, all medications that are to be administered at school must comply with the following guidelines:

1. All medications (prescription or over the counter [OTC]) must be in original container. Medication information must be clearly labeled on the container. Medications will be given as indicated on the label. The medication must be FDA approved. **ALL medication MUST be accompanied by a dated permission form signed by the parent/guardian.**
2. The over-the-counter medication must be age appropriate and may not be given more than three consecutive school days without a physician's order to do so.
3. Medications purchased or prescribed in a foreign country (for example, Mexico) cannot be given.
4. No medication is supplied by the school.

_____ Initial

5. No controlled medication for pain (ex: Narcotics) or any prescribed medication for behavior control (ex: Ritalin, Concerta, Focalin, or Strattera) will be sent home with students. Whenever possible, these types of medication should be given at home. **ALL medications of this type MUST be picked up by a parent or legal guardian.**
6. MISD Health Services **STRONGLY RECOMMENDS** that all medications be delivered to the clinic by a parent or legal guardian. MISD will not accept responsibility for these medications until they are given to the nurse or office staff.

Student Name: _____ D.O.B._____ ID#/Grade_____

First Name Last name

DATE	MEDICATION	DOSAGE	ROUTE	TIME TO BE GIVEN
Comments				
Comments				
Comments				
Comments				

[ ] At the end of school year, **parent/guardian** or **student (please circle)** to collect ALL medications. _____ (Initial)

[ ] Medication not picked up by parent or student at the end of the school year will be thrown away. _____ (Initial)

I request that the above medications be given to my child as directed. I hereby give permission for the school nurse to contact the prescribing physician with any questions related to the above medications. _____

PRINT: Parent/Guardian First and Last Name **Date**

_____

Day time Phone Number

_____ _____ _____

Parent/Guardian Signature **Date** **Initial**

EXHIBIT A (PAGE 2)

Name_____ Medication_____ BIN#_____
Dose _____ Date_____
Teacher_____ SIGNATURE_____(____) SIGNATURE_____(____)
Grade _____ ID#_____ SIGNATURE_____(____) SIGNATURE_____(____)
ALLERGIES:_____ SIGNATURE_____(____) SIGNATURE_____(____)

Monday	**Tuesday**	**Wednesday**	Thursday	**Friday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8/22	8/23	8/24	8/25	8/26	8/29	8/30	8/31	9/1	9/2
9/5 Holiday	9/6	9/7	9/8	9/9	9/12	9/13	9/14	9/15	9/16
9/19	9/20	9/21	9/22	9/23	9/26	9/27	9/28	9/29	9/30
10/3	10/4	10/5	10/6	10/7	**10/10 Teacher Work Day**	10/11	10/12	10/13	10/14
10/17	10/18	10/19	10/20	10/21	10/24	10/25	10/26	10/27	10/28
10/31	11/1	11/2	11/3	11/4	11/7	11/8	11/9	11/10	11/11
11/14	11/15	11/16	11/17	11/18	**11/21---11/25 Thanksgiving Holiday**				
11/28	11/29	11/30	12/1	12/2	12/5	12/6	12/7	12/8	12/9
12/12	12/13	12/14	12/15	12/16	12/19	12/20	**12/21-1/6 Christmas Holidays**		
1/9	1/10	1/11	1/12	1/13	**1/16 MLK Day**	1/17	1/18	1/19	1/20
1/23	1/24	1/25	1/26	1/27	1/30	1/31	2/1	2/2	2/3
2/6	2/7	2/8	2/9	2/10	2/13	2/14	2/15	2/16	2/17
2/20 Holiday	2/21	2/22	2/23	2/24	2/27	2/28	3/1	3/2	3/3
3/6	3/7	3/8	3/9	**3/10 Snow Day**	**3/13—3/17 Spring Break Holiday**				
3/20	3/21	3/22	3/23	3/24	3/27	3/28	3/29	3/30	3/31
4/3	4/4	4/5	4/6	4/7	4/10	4/11	4/12	**4/13 Snow Day**	4/14 **Holiday**
4/17 Holiday	4/18	4/19	4/20	4/21	4/24	4/25	4/26	4/27	4/28
5/1	5/2	5/3	5/4	5/5	5/8	5/9	5/10	5/11	5/12
5/15	5/16	5/17	5/18	5/19	5/22	5/23	5/24	5/25	5/26
5/29 Holiday	5/30	5/31	6/1	6/2					

MISD MEDICATION ADMINISTRATION LOG 2016 - 2017

EXHIBIT B

AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT OF A STUDENT

Student's name: _____

Date of birth: _____ Grade: _____

Name or parent or guardian: _____

Address: _____

Work phone: _____ Home phone: _____

Mobile phone: _____

Local person to contact if parent or guardian cannot be reached:

Name: _____

Phone: _____

Relationship to the student: _____

Medical Conditions: _____

Medications or drugs to which the student has had an allergic or adverse reaction: _____

IF STUDENT TAKES MEDICATIONS, PLEASE COMPLETE MEDICATION PERMISSION FORM & NOTIFY MISD PERSONNEL***

Does this student have an Individual Health Plan or an Emergency Action Plan on file with school nurse? Y _____N_____ (INITIAL)***

Does this student have a form on file with the nurse allowing them to self carry an inhaler or EPI-PEN? Y _____N_____ (INITIAL)***

***** IF YES to ANY, NOTIFY SCHOOL NURSE ONE WEEK PRIOR TO SCHOOL TRIP**

School Nurse: _____

Signature: Date:

EXHIBIT B (PAGE 2)

Student's physician or other preferred health-care provider:

Name: _____

Phone: _____

Student's dentist:

Name: _____

Phone: _____

Part 1:

I hereby authorize the Superintendent of Midland Independent School District or a designated representative to secure any and all emergency medical care and treatment for _____ *(student's name)* for acute illness suffered, injury sustained, or other situation requiring emergency medical treatment while at school or participating in school-related activities.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

☐ I do have medical insurance coverage for my child with:

_____ (Attach photocopy of insurance card).

☐ I DO NOT have medical insurance coverage for my child.

_____ _____
Signature of parent or guardian Date

I understand that the District will attempt to contact me as soon as possible if such action is necessary.

_____ _____
Signature of parent or guardian Date

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.

EXHIBIT C

MIDLAND INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES DEPARTMENT

AUTHORIZATION FOR SELF CARRY AND SELF ADMINISTRATION OF ANAPHYLAXIS MEDICATION

Student Name: _____ DOB: _____
Homeroom Teacher: _____ Grade/Student ID#: _____
Home #: _____ Work #: _____Cell _____
Emergency Contact: _____
Home #: _____ Work #: _____ Cell #: _____
PRINT Parent /Guardian First and Last Name

_____
Parent/Guardian Signature

_____
==========
Physician Please Check:

____ It is my professional opinion that _____ should be allowed to Carry and Self-Administer the following medication(s) at school or school related events for management of his/her Severe Allergy. This student has been instructed in the proper way to use his/her medication(s) and understands that these medications cannot be shared with any other person.
Medication Name: _____ Dose: _____
When to use: _____

How often can mediation be repeated? _____At what interval? _____

Additional instructions:
_____

Physician Signature:

_____

Print Physician's Name: _____ Date: _____

Office #: _____ Fax #: _____

EXHIBIT C (PAGE 2)

MIDLAND INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES DEPARTMENT

AUTHORIZATION FOR STUDENT SELF CARRY AND SELF ADMINISTER ASTHMA MEDICATION

Student Name: _____ DOB: _____
Homeroom Teacher: _____ Grade/Student ID#: _____
Home #: _____ Work #: _____Cell _____
Emergency Contact: _____
Home #: _____ Work #: _____ Cell #: _____
PRINT Parent /Guardian First and Last Name

_____
Parent/Guardian Signature

_____
==========
Physician Please Check:

____ It is my professional opinion that _____ should be allowed to Carry and Self-Administer the following medication(s) at school or school related events for management of his/her Severe Allergy. This student has been instructed in the proper way to use his/her medication(s) and understands that these medications cannot be shared with any other person.
Medication Name: _____ Dose: _____
When to use: _____

How often can mediation be repeated? _____At what interval? _____

Additional instructions:
_____

Physician Signature:

_____

Print Physician's Name: _____ Date: _____

Office #: _____ Fax #: _____

EXHIBIT D

UNLICENSED STAFF TRAINING

MEDICATION ADMINISTRATION CHECKLIST

Verbal instruction given and return demonstration shown on the following:

★ ____Check student health record (green binder) to ensure permission form is on file

★ ____ Review 7 Rights of Medication Administration

★ ____ Correctly complete required documentation after administering medication

★ _____ Medications kept in original container with label and locked cabinet at all times

Correct administration of medications (check all that apply):

★ ____Oral Meds

★ ____Inhalers

★ ____Nebulizers

★ ____Eye drops

★ ____Ear drops

★ ____Topical ointments

★ ____Rectal medications

For EPI pen administration and UDCA (Unlicensed Diabetic Care Assistant) Training, see additional training documentation

Review Medication Regulations Annually

By signing this training record, I agree that I have had the opportunity to ask questions and understand the procedures that I have been trained to provide in the absence of the school nurse.

Signature:_____Title:_____Date:_____

Signature:_____Title:_____Date:_____

Signature:_____Title:_____Date:_____

Signature:_____Title:_____Date:_____

Training conducted by: _____(RN STAFF)_____

Print Name Signature

School Year _____Campus _____

EXHIBIT E

MIDLAND INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES DEPARTMENT

Medication Administration Incident Report

Campus:___ _____ Date: _____ __
Name of student: _____Grade/ID #: _____
Date and time of error:

_____
Name of person administering medication:

_____
Name of Medication: _____
Dosage prescribed: _____
Name of Physician:

_____
Describe circumstances leading to error:

_____
_____
_____ _____
Describe action taken:

_____
_____
_____
Person(s) notified of error:
Supervisor: _____ Date: _____
Principal: _____ Date: _____
Parent: _____ Date: _____
Physician: _____ Date: _____
Signature (person completing report):

_____
Follow-up information, if applicable:

_____

EXHIBIT F

MISD HEALTH SERVICES

Authorization to Release Medication to MISD Employee

Date: _____Student Name & ID: _____

Home campus: _____

Name of medication(s): _____

_____

Instructions for administration:

_____

_____

_____

Initial here if Individual Health Plan or Emergency Care Plan attached_____

Pill count (for controlled substances ONLY): _____

Nurse signature: _____ Clinic phone #_____

MISD employee signature & position:

_____

Date medication returned to home campus: _____

Pill count upon return (for controlled substances ONLY): _____

Nurse signature: _____

MISD employee signature & position:

_____