ESTELL MANOR SCHOOL DISTRICT

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MEDICATION POLICY

The administration of medication by school personnel is discouraged by the NJ State Department of Education and is not normally a function of education. Some children with chronic diseases, however, may require medication during the course of the school day. With consent regarding your student's medication, you agree to the following. School Policy 5141.21 Administering Medication • Regulation

The following are required for the school nurse to give medications:

1. The parent or guardian must provide a written request for the administration of the prescribed medication at school. Medications that cause drowsiness should NOT be given before or during school hours.
2. Written orders are to be provided to the school nurse from the private physician, detailing the diagnosis or type of illness involved, the name of the drug, dosage, time of administration, length of time, and possible side effects.
3. The medication shall be brought to the school nurse directly by a parent or guardian.
4. The medicine shall be brought to school in the ORIGINAL container, appropriately labeled by the pharmacy. No loose medication will be administered. Check for expiration date as it is the responsibility of the parent/guardian to make sure the school does not receive expired medication. Refill medication in a timely manner.
5. The school nurse will maintain a secure locked space for safe storage of medications at all times.
6. The school nurse will maintain the records for documentation for administering medication to students.
7. A copy of this regulation will be provided to parents upon request for the administration of medication in the schools. Please see the school policy on medication.
8. The school nurse shall maintain a system by which parents are informed of their obligation to retrieve unused medication. If unused medication is not retrieved within two (2) weeks of notice, the nurse shall dispose of the medication in accordance with proper medical control

In accordance with NJ State Law, a student may be granted permission to self-administer a medication for asthma or other potentially life-threatening illness.

ALL MEDICATIONS MUST BE PICKED UP BY THE PARENT ON THE LAST DAY OF SCHOOL. ANY MEDICATION LEFT WILL BE DISPOSED OF AT THE END OF THE LAST DAY.

Complete 2 SIDES **School Year**_____ **Grade**_____

Date: _____

To Whom It May Concern: I request that the school nurse administer: _____ to my child: _____ during school hours as prescribed by the physician.

Medications may not be carried by students (see self-carry orders for emergency medications)
1. Please administer medications on schedule even on early dismissal day. _____Yes _____ No
2. I authorize the sharing of information, verbally and /or in writing, related to my child's health between the school nurse (or designee) and the healthcare provider listed below.
3. I authorize the sharing of information, verbally and/or in writing, related to my child's health between the school nurse (or designee) and school staff.
4. The school nurse shall maintain a system by which parents are informed of their obligation to retrieve unused medication. If unused medication is not retrieved within two (2) weeks of notice, the nurse shall dispose of the medication in accordance with proper medical control. Last day of school all medication is disposed of by the school nurse if not picked up by the time of student dismissal.
5. I am aware that a parent/guardian must bring the medication to the school nurse in its original, labeled container. See School policy 5141.21If Self Carry SEE Policy and sign other forms_____

Any known allergies_____
Name of Parent/Guardian _____
Signature of Parent/Guardian_____Date_____
Emergency name/phone number _____

Physician Completes: Authorization is hereby given for medication to be administered in school to:
Student Name _____Date of Birth _____

Diagnosis:_____

Medication: _____

Dosage and frequency: _____
Duration prescribed _____ School Year _____
Possible side effects: _____
Other medications taken by students that might interfere with the effects of the ordered medication: _____
Student needs to take medication while attending field trips: _____ Yes _____ No

Name Physician (print) _____

Signature of Healthcare Provider/ Phone #/ Date _____

END-OF-YEAR MEDICATION REMINDER

School year_____

Please pick up any unused medication(s) that your child has in the school office by the last day of school. The school cannot store medication in the office over the summer and unclaimed medications will be destroyed on the last day of school.

Remember, if your child needs any medication(s) during the school day, including all over-the-counter medications, such as Tylenol, Benadryl, and Advil, a medication authorization form must be completed and signed by both a physician and the parent/guardian. This goes for lozenges also which can not be self-carried (potential choking hazard, PreK program).

These forms are available in the nurse's office. In addition, the medication must be brought to school in the original container, properly labeled with the student's name by an adult. Plastic baggies are not acceptable. If over-the-counter medications once we have doctor's orders it must come in unopened.
Thank you for your cooperation in maintaining a safe environment for our students.

Per state regulations, any medication left on the last day of school is to be disposed of. This includes students who will return next year. A new physician's order and new medication(s) are to be brought into school at the beginning of each school year.

BOE policy code 5141.21 Administering Medication can be found online at the Estell Manor webpage. The school nurse shall maintain a system by which parents are informed of their obligation to retrieve unused medication. If unused medication is not retrieved within two (2) weeks of notice, the nurse shall dispose of the medication in accordance with proper medical control If you have any questions or concerns, please contact the school nurse or the school office.

Student's Name_____ GR_____

Parent's Signature_____

Date_____

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Acute Seizure Action Plan

Name: _____ Birth date: _____ Today's date: _____

Care partner phone numbers: _____

Provider name/facility: _____

Provider phone numbers: _____

Usual Seizure Pattern

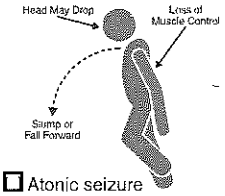
Triggers: _____

Pattern of seizures: _____

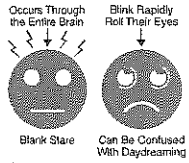
Allergies: _____

What the seizures normally look like (Check all that apply)

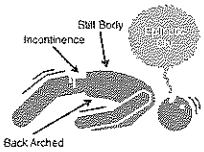
Describe: _____



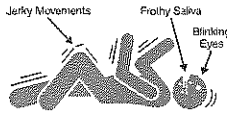
☐ Atonic seizure (also called drop)



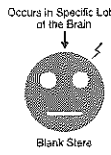
☐ Absence seizure (also called petit mal)



☐ Tonic seizure



☐ Clonic seizure



☐ Focal impaired awareness seizure (also called complex partial)

NOTES: _____

Care

Standard Care Needed

If this happens, _____

_____ **provide standard care**

Time the seizure

NOTES: _____

Keep person safe

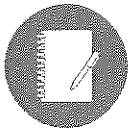
NOTES: _____

Don't restrict

NOTES: _____

Stay with person

NOTES: _____



Keep a record

NOTES: _____

Provide Rescue Treatment

If this happens, _____

_____ **provide standard care** (above) *and* **rescue treatment**

☐ Rectum

☐ Nose

☐ Mouth

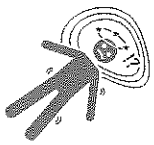
Specific instructions: _____

☐ Other: _____

Call for Emergency Help

If any of these happen,

☐ **Seizure longer than ____ minutes**



☐ **Unusual seizure**

☐ **Injury/Blue lips**

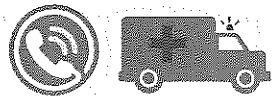
☐ **Other:** _____

_____

_____

_____

Get help now



Call Healthcare Provider if: _____

Call for Emergency Help if: _____

NOTES: _____

NOTES: _____

Healthcare Provider Authorization

Signature: _____ Provider Printed Name: _____ Date: _____ For use from: _____ to: _____