Medication Administration Procedures

In accordance with school policy and state guidelines, medication(s) should be given at home either before and/or after school. When this is not possible, prior to administering medication at school, the following MUST occur:

1. A licensed prescriber's written order for each medication to be administered in school must be provided. Medication permission form is located on the school district website (www.elcosd.org). The written order shall include name of child, name of medication, route and dosage, time of administration, length of administration, any specific directions, student allergies, a list of other medication prescribed, and a prescriber's signature and phone number.

2. All prescription medication must be in the original pharmacy labeled container, which includes the name of the child, medication name, dosage, and time and route of administration. A pharmacy can provide a bottle with instructions for administration during school hours. Prescribed over the counter medication (i.e. Ibuprofen, Acetaminophen) must be in its original container, unopened with a readable label, and a valid expiration date.

3. **Students are not permitted to transport medication to school**. A parent/guardian or another adult designated by the parent/guardian shall deliver medication to the health office.

4. NO prescription or over the counter medications may be in a student's possession, unless indicated by a prescriber on an emergency basis. Exceptions include emergency inhaler, emergency epinephrine autoinjector, or an insulin pump.

5. All medication shall be administered by the certified school nurse, licensed nurse (RN,LPN), or by a parent/guardian. One exception is an emergency epinephrine autoinjector which may be administered by a trained non-licensed individual.

6. A parent/guardian may come to the health office to administer medication to their child.

7. All medication orders <u>expire at the end of the school year.</u> Parents/Guardians must pick up any unused medication(s) at the end of the school year, these will not be sent home with students. Any medications not picked up by a parent/guardian will be discarded one day after the conclusion of the school year and documented.

If you have any questions or concerns, please contact one of the Certified School Nurses:

HS/MS: (717)-866-7447
Elementary: (717)-866-4521

Please read both sides, complete upper portion of form on the opposite side. Your child's physician/prescriber must complete the remaining portion.

Eastern Lebanon County School District
Medication Administration Consent & Licensed Prescriber Order

Student Name: _____ Date/Time: _____

School: _____ Teacher/Grade: _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, **each student must provide** the school nurse with a Medication Administration Consent & Licensed Prescriber Order form signed by the student's parent/guardian and by a licensed prescriber. **All medications must be in an original prescription bottle/container from the pharmacy.**

Parent/Guardian Consent

I give permission for my child, _____, to receive the following medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions. I also give permission for the school nurse to discuss with the student's medical provider this medication and the condition for which it is prescribed.

Parent/Guardian Signature:_____ Date: _____

Parent/Guardian Name (printed): _____Phone:_____

Licensed Prescriber Medication Order: TO BE COMPLETED BY THE PRESCRIBER

(Licensed prescribers include: licensed physician, podiatrist, dentist, optometrist, certified registered nurse practitioner, and physician assistant)

Patient's Name: _____ Date:_____

Name of Medication, Route, & Dosage:_____

Time of Administration:_____ Reason:_____

Directions:_____

Restrictions and/or side effects:_____

Discontinuation date:_____ Allergies:_____

In the event of a field trip, is it permissible to have this student's medication temporarily withheld? **Yes** **No**

Given at an alternative time? **Yes** **No**

If no please explain what is medically appropriate:_____

_____

Physician Name (printed):_____ Date:_____

Physician Signature:_____Office phone:_____

This section to be completed for student to be authorized to carry and self-administer an inhaler and/or epinephrine auto injector.

I request this student be permitted to carry and self-administer their asthma inhaler/Epi Auto Injector **Yes** **No**

As the student's health care provider, I verify that they have been taught proper use of their inhaler/Epi Auto Injector, has adequate knowledge of asthma/anaphylaxis and how to control it, and is thought to be responsible enough to carry their inhaler/Epi Auto Injector and use it correctly without supervision.

Physician Signature:_____ Date:_____

Revised June 2023