REACHING ALL MINDS ACADEMY

NUMBER: 2.8 **EFFECTIVE DATE:** 4/10/14 **PAGES: 6**

SECTION: Operations
SUBJECT: Administering Medication

REPLACES: N/A **REVISION NUMBER/DATE:** N/A

School personnel are not to administer medication to students except when medications are prescribed by a physician or other practitioner authorized to prescribe medication. If a physician/practitioner determines that medication administration is necessary during school hours, school personnel will abide by the following policy:

1. Responsibilities of Parents/Guardians:
   a. To obtain from the school and complete a form authorizing administration of medication to their child. This form will contain the following:
      - Student's name
      - Name of medication
      - Time and directions for administration
      - Dosage and route of administration
      - Possible side effects
      - Signature of physician or practitioner prescribing the medication
      - Signature of parent/guardian
   b. To obtain from the pharmacist a separate container for school with the following labeling:
      - Student's full name
      - Name and dosage of medication
      - Time and directions for administration
      - Prescriber's name
      - Date
   c. To bring limited quantities of their child's medication to school personally.
   d. To inform the school administration of any change in the medication or its administration by providing a note from the prescriber.

2. Responsibilities of the Principal or Designee:
   a. To inform parents, teachers and students of the school medication policy and to ensure that:
      - Appropriate school personnel are informed about the medication
      - The proper dosage is given to the student and is recorded or logged.
      - The medication is kept in a locked location.

- Unused medication is picked up by the parent/guardian only. Medication not picked up within one week after the school year will be destroyed.

b. To require that parents/guardians who request administration of medication in the schools submit new consent forms annually.
c. To inform students that sharing of medication at school is prohibited.
d. To deny a request for medication at school if the request is considered inappropriate.

3. Responsibilities of the Student:
   a. To know and follow the regulations of the medication policy, as age appropriate.
   b. To avoid sharing medication with other students.

4. Responsibilities of the School Nurse:
   a. To monitor medication administration procedures, periodically audit medication administration and documentation, and provide any necessary consultation concerning medication to the appropriate school personnel in his/her assigned school(s).
   b. To provide training for school staff assigned the responsibility of administering and safely securing medications at school.
   c. To serve as liaison with parents, physicians, and the appropriate individuals regarding status and effectiveness of student's medication treatment plan.
   d. To serve as a consultant to principals, school staff, parents and students regarding medication safety and concerns at school.

5. Policy exceptions:
   a. Syrup of Ipecac may be administered under the direction of the student's parents/guardian, physician, or poison control center to induce vomiting if a student has ingested poison or a drug overdose.
   b. All medications administered at school require a consent signed by the parent/guardian and physician/practitioner. There are no exceptions for the administration of medications that are given on a long term, short-term, over-the- counter or on an "as needed" basis.
   c. Some medications such as inhalers or emergency injections can be self administered and kept by the student with written medical provider permission. The Board of Directors assumes no responsibility for students who self medicate.

REACHING ALL MINDS ACADEMY

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name_____ Date of Birth: ____/____/____

Medication: _____ Dosage:_____ Route:_____ Frequency:_____

Time(s) medication is to be given: _____ Dates to be given from: _____/_____/_____ to _____/_____/_____
(Medication request will be in effect until the beginning of the next school year unless otherwise specified)

Type of Medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

Significant Information (side effect, adverse & omission reactions):_____

Contraindications for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office: _____ Telephone: _____

b. Take child immediately to the emergency room at: _____

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed and the time to be given).

Physician's Signature:_____Telephone:_____ Date:_____/_____/____

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature_____ Telephone:_____ Date_____/_____/_____

----------(SCHOOL USE ONLY)----------

Name and title of person to administer medication:_____

Approved by: _____(Principal's Signature) _____(Date)

Reviewed by: _____(School Nurse's Signature) _____(Date)

1. MEDICATION CHECK-IN & SIGN-OUT LOG

Date	Medication	Amt. Rec'd	Received by (signature)	Received from (signature)

RAM ACADEMY
MEDICATION VARIANCE FORM

Name of Student_____Date/Time_____

Name of Medication_____ Dose given/missed
(Circle)

Name of person administering medication_____

Name of person completing form_____

Location variance occurred_____

Briefly describe the error and circumstances leading up to/resulting in the error (State only facts, No opinions):
_____

_____

_____

_____

_____

Actions taken/treatments given:
_____

_____

_____

Persons notified of error:
Principal _____

Parent _____

Physician (if applicable) _____
`

Other _____

Any suggestions for avoiding variance in the future? _____

_____

_____

Signature of person completing form _____

MEDICATION AUTHORIZATION FOR SELF-ADMINISTRATION

Reaching All Minds Academy

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name: _____ Date of Birth: ____/____/____

School: _____ Telephone: _____ Fax: _____

The above named student has a medical condition that requires self-medication at school. I have received the Reaching All Minds Academy Self-Administration Policy and agree that this student has the knowledge and maturity to self-manage his/her medication safely and correctly.

Medication: _____ Dosage: _____ Route: _____ Frequency: _____

Time(s) medication is to be given: _____ Dates to be given from: ___/___/___ to ___/___/___
(Medication request will be in effect until the beginning of the next school year unless otherwise specified.)

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

Significant Information (side effects, adverse & omission reactions): _____

This medication will be furnished by parent or guardian in a pharmacy labeled container with identifying information (i.e. name of child, medication dispensed, dosage prescribed and time to be given).

Physician Signature: _____ Physician Name (print): _____

Telephone: _____ Date: _____/_____/_____

I have read the School's Self-Administration Policy and I agree that my son/daughter named above has sufficient maturity and knowledge to use the above prescribed medication safely and correctly. I understand that:

- The only liability which the school can assume is to comply with the terms of this policy.
- The school can assume no liability for monitoring the self-administration, including the frequency and dose or the failure to self-medicate when necessary.
- My son/daughter must comply with the procedures outlined on this form.

Parent Signature: _____ Telephone: _____ Date: ___/___/___

I have read the School's Student Self-Administration Policy and I agree that I have sufficient maturity and knowledge to use the medication named above safely and correctly. I agree to:

- Keep medication I my possession at all times and not leave it in a place accessible to other students.
- Not allow or offer any use to other students
- Use medication in a responsible manner, in accordance with my physician's orders.
- Notify the school office or school nurse if I am having more difficulty than usual with my health condition.

Student Signature: _____ Date: ___/___/___

Review with Student:
_____ Demonstrates correct use/administration of medication
_____ Recognizes need and proper timing for medication as prescribed by physician
_____ Identifies a proper location and method to carry medication
_____ Knows health condition well
_____ Keeps a second labeled container in nurse's office or main office (as indicated)
_____ Review Emergency Action Plan

Nurse: _____ Date: ___/___/___ Principal: _____