PRINCETON CITY SCHOOLS
EMPOWERING EACH STUDENT FOR COLLEGE, CAREER, AND LIFE SUCCESS

Office of Student Services

Medication Delivery While At School

Dear Parents:

Many students are able to attend school regularly only through effective use of medication in the treatment of disabilities or illnesses that will not hinder the health or welfare of others. If possible, all medication should be given by the parent at home. **Medications which are ordered once, twice or three times daily should not be given at school.** Medications ordered four times daily, or for attention deficit disorder, or for acute situations (example: asthma attacks, pain, etc.), can be administered at school after receipt of proper paperwork from a "licensed health professional authorized to prescribe drugs" or "prescriber" as defined in Ohio Revised Code (ORC) 4729.01 as: "an individual who is authorized by law to prescribe drugs or dangerous drugs or drug therapy related devices in the course of the individual's professional practice.

Medication Permissions forms must be updated each school year for all medication(s) prescribed.

Ohio Revised Code 3313.713 also requires the Princeton City School District Board of Education to adopt a policy on the authority of its employees to administer drugs prescribed to students enrolled in the schools of the district. The policy provides that no drug prescribed for a student shall be administered until the following occur:

- A written request signed by the parent, guardian, or other person having care or charge of the student is received that the drug be administered to the student
- A statement signed by the prescriber is received that includes all of the following information:
  - The name and address of the student;
  - The school and class in which the student is enrolled;
  - The name of the drug and the dosage to be administered;
  - The times or intervals at which each dosage of the drug is to be administered;
  - The date the administration of the drug is to begin;
  - The date the administration of the drug is to cease;
  - Any severe adverse reactions that should be reported to the prescriber and one or more phone numbers at which the prescriber can be reached in an emergency;
  - Special instructions for administration of the drug, including sterile conditions and storage.
- In the event of prescription changes, the parent, guardian, or other person having care or charge of the student agrees to submit a revised statement signed by the prescriber
- The medication is received by the person authorized to administer the drug to the student for whom the drug is prescribed in the container in which it was dispensed by the prescriber.
- All medications must be delivered to the school nurse by the student's parent or guardian. Children may not bring medications to school.

This policy applies to both prescription and non-prescription medications.

If you have any questions regarding this policy, please contact your building principal or nurse.

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PRINCETON CITY SCHOOLS

ADMINISTRATION OF MEDICATION

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any ***prescribed or over-the-counter*** *medication to a student. Please complete this form and return to the school office.*

Name of Student _____DOB _____ Grade_____ Homeroom _____

Address _____ Telephone (home/work/cell)_____

Allergies _____

To be completed by LICENSED PRESCRIBER

Condition for which medication is administered _____

Name of medication: _____dosage: _____ frequency: _____ route: _____

Time or indication for administration _____

Specific instructions for administration and/or storage requirements _____

Possible side effects to be noted/reported _____

Effective Date(s) _____ Expiration date of this request _____

For ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS – In my opinion, this student shows the ability to be responsible for carrying and self-administering the above medication and has received adequate instruction in use thereof. _____YES _____NO
Instructions to follow in the event medication does not produce expected relief: _____

_____

_____

Licensed Prescriber Signature **Date**

Prescriber Name _____
(Please Print)
Address _____

Phone Number _____

To be completed by PARENT/GUARDIAN

NOTE: NO EMPLOYEE WHO IS AUTHORIZED BY A BOARD OF EDUCATION TO ADMINISTER A PRESCRIBED MEDICATION AND WHO HAS A COPY OF THE MOST RECENT PRESCRIBER'S STATEMENT WOULD BE LIABLE IN CIVIL DAMAGES FOR ADMINISTERING OR FAILING TO ADMINISTER THE DRUG UNLESS HE/SHE ACTED IN A MANNER THAT WOULD CONSTITUTE "GROSS NEGLIGENCE OR WANTON OR RECKLESS MISCONDUCT."

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs or if the medication has been discontinued.
2. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
3. Cooperate with school personnel in assisting my child comply with medication administration instructions.
4. All medications must come to school in the original container from the pharmacist.

_____ _____

Parent/Guardian Signature Date Contact Phone Number(s) – home/work/cell

I hereby authorize the building nurse to share necessary medication information about my child with the appropriate school staff. This information will be shared in a confidential manner. This authorization is valid for the current school year only. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act.

_____ _____

Parent/Guardian Signature Date Contact Phone Number(s) – home/work/cell

FOR INHALERS, EPI-PENS, AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. I further understand that my child will demonstrate proper administration and sign a contract stating he/she will be responsible for the medication during school. __ Yes __ No ___Initials

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The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____