Student Medication Authorization Form 8

ARCHDIOCESE OF WASHINGTON- Catholic Schools

NOTE: This is a release and indemnification agreement authorizing the administration of medication. It is NOT an authorization for an inhaler or an epi-pen.

Please use a separate form for each medication.

PART I: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Sex: male □ female □ Birth Date: _____

School's Name: _____ School Year/Grade _____

Allergies:_____

Medication: □Renewal □NEW ***If new, the first dose must be given at home** First dose given: Date/Time _____

PART II: TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER WITH NO ABBREVIATIONS

St. Pius X Regional School discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by the parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined herein.

Diagnosis: _____Medication and Route: _____

Dosage to be given at school & interval for repeating: _____ Time to be given:_____

Common Side Effects: _____

Effective Date: Start _____ End _____

If student is taking more than one medication at school, list sequence in which medications are to be take: _____

_____

Licensed Healthcare Provider:_____ Phone: _____

Signature of LHCP: _____ Date: _____

PART III: TO BE COMPLETED BY PRINCIPAL AND REGISTERED NURSE

Check as appropriate:

□ Parts I, II AND Parent Information are completed including signature. (It is acceptable if Part II is written on the LHCP stationery or prescription pad).

□ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

Signature of Nurse: _____ Date: _____

Signature of Principal: _____ Date: _____

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here and in the Archdiocese of Washington Catholic Schools Policies and district or state guidelines.

2. Schools do NOT provide medication for students use.

3. Medication should be taken at home whenever possible. The first dose of any new medication must be given at home.

4. Medication Authorization forms are required for each prescription and over-the-counter (OTC) medication administered in school.

5. All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.

6. All Over the Counter (OTC) medication must be in the original, sealed container with the name of the medication and its expiration date clearly visible. Parents/guardians must label the original container of the OTC with:

    - Name of student
    - Exact dosage to be taken in school
    - Frequency or time interval dosage is to be administered

7. The parent or guardian must transport medications to and from school.

8. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.

9. Parents/ guardians are responsible for submitting a new medication authorization form to the school at the beginning of the school year and each time there is a change in the dosage or the time of medication administration.

10. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.

    - Student name
    - Date of Birth
    - Diagnosis
    - Signs or symptoms
    - Name of medication to be given in school
    - Time and frequency to give medications, as well as exact time interval for additional dosages
    - Sequence in which two or more medications are to be administered
    - Duration of medication order or effective start and

11. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.

12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.

13. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within the period will be destroyed.

14. Students are NOT permitted to self-medicate. The school does not assume responsibility for medication taken independently by the student. Exceptions may be made on case-by-case basis for students who demonstrate the capability to self-administer emergency life-saving medications (e.g. inhaler, EpiPen)

I hereby request designated St. Pius X Regional School personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the Archdiocese of Washington, the parish, school personnel, employees, or agents from lawsuits, claim expense, demand or action, etc., against them for helping my child use this mediation. I have read the procedures outlined above and assume responsibility as required.

Name of Parent/ Guardian: _____ Home Phone: _____

Signature of Parent/ Guardian: _____ Date: _____