

LINE MOUNTAIN SCHOOL DISTRICT

Line Mountain Middle/High School

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GUIDELINES FOR THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The Line Mountain School District recognizes that parents have the primary responsibility for the health of their children. Although the district strongly recommends that medication be given in the home, it realizes that the health of some children requires that they receive medication while in school.

Parents should confer with the child's physician to arrange medication time intervals to avoid school hours whenever possible. **When medication absolutely must be given during school hours, certain procedures (1 thru 3 listed below) must be followed before the medication can be administered.**

1. The physician must complete Section 1. of this form.
2. Parents must complete and sign Section 2. of this form.
3. **Any medication** to be given during school hours must be delivered directly to the School Nurse, the School Principal or Principal's Designee. The medication must be brought to the school in the **original pharmaceutically dispensed and properly labeled container.**

Section 1. (To be completed by the physician)

Child's Name/Grade- _____
Reason for medication/treatment- _____
Name of medication/treatment- _____
Dose and frequency- _____
Start Date _____ End Date _____
Special storage requirements None _____ Refrigerate _____
Possible side effects or curtailment of specific school activities- _____

Date Physician's Signature Physician's name (printed) phone #

Section 2. (To be completed by parent)

I the undersigned parent of the above-mentioned child hereby give permission for the School Nurse or Principal's designee to perform the treatment and/or administer the medication indicated above. I will not hold any person or group liable if the directions of the doctor are followed, and hereby release the Line Mountain School District from any liability arising out of providing the treatment and/or administering the medication indicated. I also give the school nurse my permission to contact the prescribing physician if necessary to clarify questions concerning this treatment and/or medication.

Please note time to be given and any additional parental instructions.

Parent's Signature _____ Date _____



IMPORTANT: If medication is for an Inhaler or Epi-Pen, the reverse side of this form must also be completed.





Asthma Inhaler or Epi-Pen Contract for use during school hours



Dear Parent or Guardian,

So that the Line Mountain Schools can provide the best care for your child, please have the bottom portion of this form completed. You will notice that if you choose Option #2, it will require your signature, as well as, that of your child and the child's physician.

Option #1:

Your child comes to the health room where his/her inhaler is stored and uses it under supervision. The advantage is that the medication will be used correctly, in the proper amount, and a record of its usage will be maintained.

Option #2:

Qualified students may be allowed to carry their Inhalers/ Epi-Pens. However, the student is required to notify the Nurse or Principal's Designee that the Medication was used so that it can be documented. If the student is found to be misusing the medication, the parent and physician will be notified and the suggestion made that the student follow Option #1.

Parents may want to consider keeping "spare" medication in the Nurse's Office in the event of an emergency, for example, medicine needed and is not in school, insufficient medicine or student unable to self-administer and location of medication is unknown.

(Student to complete this section)

Contract Between Student, Parent, Physician and School Nurse for Permission to Carry Inhaler(s).

1. Student agrees NEVER to share any medication with another person.
2. Student agrees Epi-Pen, he or she must report to the Nurse's Office immediately.
3. Student agrees, if that he has and uses an Inhaler, that after two (2) puffs, if there is not marked improvement, he/she will immediately go to the Nurse's Office.

Student signature _____ *Date* _____

(Parent to complete this section)

I give permission for my child (name & grade) _____ to carry the inhaler/Epi-Pen described on the reverse side of this form. I understand that he/she must follow the rules listed above. I will notify the school nurse of ANY changes in medication or my child's condition.

Parent Signature _____ *Date* _____

(Physician to complete this section)

I have instructed _____ in the proper way to use the above medication. It is my professional opinion that this student be allowed to carry and self-administer said inhaler.

It is my professional opinion that _____ should not carry his/her inhaler. However, it is my opinion that the student may self-administer this medication under the supervision of the School Nurse or her Designee.

It is my professional opinion that _____ should not carry his/her inhaler or self-administer the above medication. The medication is to be kept in the Nurse's office and administered by the School Nurse or her Designee.

Physician Signature _____ *Date* _____

Physician's Name (printed) _____ *Phone* _____