

EAST GUERNSEY LOCAL SCHOOLS
MEDICATION/TREATMENT ADMINISTRATION AT SCHOOL

Dear Parent:

We receive many requests to administer medication and/or treatments during the school day. The following information is intended to clarify our policy on medication and treatment administration at school:

1. **No** over-the-counter medication can be administered by school personnel without a physician's order.
2. Medication should **not** be sent to school unless it is absolutely necessary to the health and well-being of the student that it be administered during regular school hours.
3. Upon receipt of a written request, signed by the student's parent/guardian, the School Nurse, Principal and designee employed by the School Board is authorized to administer a drug prescribed by a physician. **THE SCHOOL NURSE MUST RECEIVE A STATEMENT SIGNED BY THE PHYSICIAN WHO PRESCRIBED THE MEDICATION/TREATMENT THAT INCLUDE ALL OF THE FOLLOWING INFORMATION:**
 - a. Name and address of the student
 - b. School and grade in which the student is enrolled
 - c. Name of medication and dosage to be given
 - d. Name of treatment to be administered
 - e. Times at which medication/treatment is to be given
 - f. Date the administration of medication/treatment is to begin
 - g. Date the administration of medication/treatment is to cease
 - h. Any adverse reactions that should be reported to the physician
 - i. Special instructions for administration of medication/treatment, including sterile conditions, storage and capability/responsibility to self administer medication/treatment with limited supervision
4. The parent/guardian agrees to submit a revised physician's statement signed by the physician who prescribed the medication/treatment if any of the above information changes.
5. The parent/guardian agrees to submit a revised statement **each** year.
6. **MEDICATION MUST BE IN ORIGINAL CONTAINER.**
7. **STUDENTS ARE NOT TO TRANSPORT MEDICATION TO SCHOOL.**

**EAST GUERNSEY LOCAL SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT**

To the Parent/Guardian or Adult Student:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED MEDICATIONS OR OVER THE COUNTER MEDICINE OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED IN INK.

Name of Student

Date of Birth

Street Address/City/Zip

Telephone

School Building

Home Room/Teacher

- A. I am requesting permission for my child named above to: (Circle appropriate number below)
1. Use or receive medication according to doctor's written directions on the back of this form.
 2. Receive treatment.
 3. Self administer medication. (Medication will be stored in a secure location in the office and the student will receive the medication in the presence of a school employee) in accordance with the Doctor's prescription.
- B. I will assume responsibility for safe delivery of the medication to school.
- C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment as authorized by the Doctor. **A new form must be completed.**
- D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
- E. I authorize contact directly with the physicians in such emergency reaction situations that will not supersede nor abrogate the "Emergency Medical Form".

Signature of Parent/Guardian

Date

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PHYSICIAN STATEMENT
(must be completed by physician)

STUDENT NAME: _____

To the Physician:

The East Guernsey Local School District requires all of the following information before it will administer medication or treatment to this student. **ALL SPACES MUST BE COMPLETED.**

I have prescribed the following medication: _____

Medication is to begin _____ and end on _____.
(Date) (Date)

Dosage: _____ Time of Day: _____

Is there a sliding dosage? _____ Yes _____ No If yes, please explain: _____

Refrigeration required? _____ Yes _____ No

Special Storage: _____

_____ This student is both capable and responsible to self-administer this medication/treatment with limited supervision. (Please check if this applies)

TREATMENT: The following treatment is to be provided to this student:

Beginning Date: _____ Stop Date: _____

Physician Signature: _____ Telephone: _____

Printed/Typed Name: _____ Date: _____