

Notice to Parents Regarding Medication Policy



Dear Parent/Guardian:

To protect your child's safety, the school licensed practical nurse and/or health aide (as designated by the principal) will adhere to the following medication policy. It is required that BOTH parent AND physician's signatures are on file before any prescription.

Although this may cause some inconvenience, we believe this policy is best for the continued protection of your child's safety and therefore must be followed. If we do not have your written permission and the written permission of your physician, the medication will not be given. Permission forms can be obtained by contacting your school licensed practical nurse or health aide or the school office.

For your child to receive any medication at school, please follow below medication policy:

- All Action/Care Plans will need to be submitted with a Medication Consent form.
- Administration consent form must be completed and signed by physician, parent, or legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- New permission forms must be re-submitted each school year and are necessary for any changes in medication orders.
- Over the counter medications (OTC) forms are required to be filled out and signed by parent/guardian annually. No OTC medication(s) will be administered without written consent.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Only students with written authorization from their physician and parents are allowed to self-carry medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- The medication and the signed permission forms must be brought to the school by the parent or guardian and delivered to the campus clinic health aide. Students are not to be sent to campus with medications.
- Wherever possible, please include a photo of your child with the permission form.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- When the medication is almost completed, please send the refill to school promptly.
- If your child is taken off medication, will no longer receive it at school, or if the prescription otherwise changes, please provide a dated, written note with updated prescription information of such changes as soon as possible. If medication is not picked up from the school office within ten (10) days, it will be properly disposed of.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Please contact the principal or his/her designee if you have any questions.
Thank you for your cooperation.

Aviso a los padres sobre la política de medicamentos



Estimado Padre / Tutor:

Para proteger la seguridad de su hijo, la enfermera practicante con licencia de la escuela y/o el asistente de salud (según lo designe el director) se adherirá a la siguiente política de medicamentos. Se requiere que AMBOS padres y las firmas del médico estén archivadas antes de cualquier receta.

Aunque esto puede causar algunos inconvenientes, creemos que esta política es la mejor para la protección continua de la seguridad de su hijo y, por lo tanto, debe seguirse. Si no tenemos su permiso por escrito y el permiso por escrito de su médico, no se administrará el medicamento. Los formularios de permiso se pueden obtener comunicándose con la enfermera práctica autorizada o el asistente de salud de su escuela o con la oficina de la escuela.

Para que su hijo reciba cualquier medicamento en la escuela, siga la siguiente política de medicamentos:

Todos los planes de acción/cuidado deberán presentarse con un formulario de consentimiento de medicamentos.

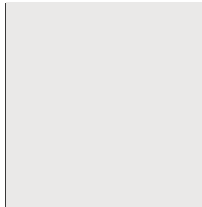
- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los nuevos formularios de permiso deben volver a presentarse cada año escolar y son necesarios para cualquier cambio en las órdenes de medicamentos.
- Los formularios de medicamentos de venta libre (OTC) deben ser llenados y firmados por el padre/tutor anualmente. No se administrarán medicamentos de venta libre sin el consentimiento por escrito.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- El medicamento y los formularios de permiso firmados deben ser llevados a la escuela por el padre o tutor y entregados al asistente de salud de la clínica del campus. Los estudiantes no deben ser enviados al campus con medicamentos.
- Siempre que sea posible, incluya una foto de su hijo con el formulario de autorización.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- Cuando el medicamento esté casi terminado, envíe la recarga a la escuela de inmediato.
- Si a su hijo se le retira el medicamento, ya no lo recibirá en la escuela, o si la receta cambia de otro modo, proporcione una nota escrita con fecha con información actualizada de la receta de dichos cambios tan pronto como sea posible. Si el medicamento no se recoge en la oficina de la escuela dentro de los diez (10) días, se desechará correctamente.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Comuníquese con el director o su designado si tiene alguna pregunta.
Gracias por su cooperación.



Safe at School®

Diabetes Medical Management Plan



(Add student photo here.)

SCHOOL YEAR:

STUDENT LAST NAME: FIRST NAME: DOB:

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PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION – PARENT/GUARDIAN TO COMPLETE

Student First Name: Last Name: DOB: Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact: Contact Phone #:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):	Meals Times:	Physical Activity:	Travels to:
Foot/Bicycle	Breakfast	Gym	Home After School Program
Car	AM Snack	Recess	Via: Foot/Bicycle
Bus	Lunch	Sports	Car
Attends Before School Program	PM Snack	Additional information:	Student Driver
	Pre Dismissal Snack		Bus

Parent/Guardian #1 (contact first): Relationship: Parent/Guardian #2: Relationship:

Cell #: Home #: Work #: Cell #: Home #: Work #:

E-mail Address: E-mail Address:

Indicate preferred contact method: Indicate preferred contact method:

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- Insulin
- Syringe/Pen Needles
- Ketone Strips
- Treatment for lows and snacks
- Glucagon
- Antiseptic Wipes
- Blood Glucose (BG)
- Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users
- Pump Supplies (Infusion Set,
- Cartridge, extra Battery/Charging Cord) if applicable
- Additional supplies:

2. View Disaster/Emergency Planning details – refer to Safe at School Guide

3. Please review expiration dates and quantities monthly and replace items prior to expiration dates

4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic: Contact #: Fax #: Email Address (non-essential communication): Other:

STUDENT LAST NAME:

FIRST NAME:

DOB:

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

		Full Support	Supervision	Self-Care
Glucose Monitoring:	Meter CGM (Requires Calibration)			
Carbohydrate Counting				
Insulin Administration:	Syringe Pen Pump			
Can Calculate Insulin Doses				
Glucose Management:	Low Glucose High Glucose			

Self-Carry Diabetes Supplies: Yes No Please specify items:
Smart Phone: Yes No

Device Independence: CGM Interpretation & Alarm Management Sensor Insertion Calibration Insulin Pumps Bolus
Connects/Disconnects Temp Basal Adjustment Interpretation & Alarm Management Site Insertion Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High:

Thirsty Frequent Urination Fatigued/Tired/Drowsy Headache Blurred Vision Warm/Dry/Flushed Skin
Abdominal Discomfort Nausea/Vomiting Fruity Breath Unaware Other:

Symptoms of Low:

None Hungry Shaky Pale Sweaty Tired/Sleepy Tearful/Crying Dizzy Irritable
Unable to Concentrate Confusion Personality Changes Other:

Has student lost consciousness, experienced a seizure or required Glucagon: Yes No If yes, date of last event:

Has student been admitted for DKA after diagnosis: Yes No If yes, date of last event:

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose:

Before Meals With Physical Complaints/Illness (include ketone testing) High or Low Glucose Symptoms
Before Exams Before Physical Activity After Physical Activity Before Leaving School Other:

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment: Device Reader Smart Phone
Insulin Pump Smart Watch iPod/iPad/Tablet

CGM is remotely monitored by parent/guardian.
Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.
May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:



Low alarm mg/dL

High alarm mg/dL if applicable

Please:

- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:

- Glucose reading is below mg/dL or above mg/dL
- If CGM is still reading below mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable.  (see CGM addenda for more information) 
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below mg/dL (<55 mg/dL DEFAULT)
above mg/dL (>300 mg/d DEFAULT)

Section 1-5 completed by Parent/Guardian

Name of Health Care Provider/Clinic:

Contact #:

Fax #:

Email Address (non-essential communication):

Other:

STUDENT LAST NAME:

FIRST NAME:

DOB:

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

Syringe	Insulin Pen (Whole Units	Half Units)	Insulin Pump (Specify Brand & Model: _____)
i-Port	Smart Pen			Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
Other				Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

DOSING to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

- Prior to Meal** (DEFAULT)
- After Meal** as soon as possible and within 30 minutes
- Snacking** avoid snacking _____ hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

Calculate meal dose using _____ grams of carbohydrate prior to the meal
 Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
 May advance to Prior to Meal when student demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose To The Nearest:

Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
 Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders:

Check for **KETONES** before administering insulin dose if BG > _____ mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.

- Parents/guardians are authorized to adjust insulin dose +/- _____ units
- Insulin dose +/- _____ units
- Insulin dose +/- _____ %
- Insulin to Carb Ratio +/- _____ grams/units
- Insulin Factor +/- _____ mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic:

Contact #:

Fax #:

Email Address (non-essential communication):

Other:

STUDENT LAST NAME:

FIRST NAME:

DOB:

6A. DOSING TABLE – HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) Other:

Ultra Rapid Acting Insulin: Fiasp (Aspart) Lyumjev (Lispro-aabc) Other:

Other insulin: Humulin R Novolin R

Meal & Times	Food Dose		Glucose Correction Dose Use Formula See Sliding Scale 6B		PE/Activity Day Dose	
	Select if dosing is required for meal	Carbohydrate Ratio: Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	Fixed Meal Dose	Formula: (Pre-Meal Glucose Reading minus Target Glucose) divided by Correction Factor = Correction Dose May give Correction dose every _____ hours as needed (DEFAULT 3 hours)		Adjust: Carbohydrate Dose Total Dose Indicate dose instructions below:
Breakfast	Breakfast Carb Ratio = _____ g/unit	Breakfast units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units		
AM Snack	AM Snack Carb Ratio = _____ g/unit	AM Snack units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units		
	No Carb Dose	No Insulin if < _____ grams	No Correction dose		Subtract _____ units	
Lunch	Lunch Carb Ratio = _____ g/unit	Lunch units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units		
PM Snack	PM Snack Carb Ratio = _____ g/unit	PM Snack units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units		
	No Carb Dose	No Insulin if < _____ grams	No Correction dose		Subtract _____ units	
Dinner	Dinner Carb Ratio = _____ g/unit	Dinner units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units		
			No Correction dose		Subtract _____ units	

6B. CORRECTION SLIDING SCALE

Meals Only	Meals and Snacks	Every	hours as needed						
to	mg/dL =	units	to	mg/dL =	units	to	mg/dL =	units	
to	mg/dL =	units	to	mg/dL =	units	to	mg/dL =	units	
to	mg/dL =	units	to	mg/dL =	units	to	mg/dL =	units	

6C. LONG ACTING INSULIN

Time	Lantus, Basaglar, Toujeo (Glargine) Levemir (Detemir) Tresiba (Degludec) Other	units	Daily Dose Overnight Field Trip Dose Disaster/Emergency Dose	Subcutaneously
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6D. OTHER MEDICATIONS

Time	Metformin Other	units	Daily Dose Overnight Field Trip Dose Disaster/Emergency Dose	Route
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Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature:

Date:

Name of Health Care Provider/Clinic:

Contact #:

Fax #:

Email Address (non-essential communication):

Other:

STUDENT LAST NAME:

FIRST NAME:

DOB:

7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

Allow Mini-Dosing of carbohydrate (i.e., 1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.

Allow student to carry and consume snacks School staff to administer

Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

Pre-programmed Temporary Basal Rate Named _____ (OmniPod)

Temp Target (Medtronic) Exercise Activity Setting (Tandem) Activity Feature (Omnipod 5)

Start: minutes prior to exercise for minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

Initiated by: Student Trained School Staff School Nurse

May disconnect and suspend insulin pump up to minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

prior to exercise every 30 minutes during extended exercise following exercise with symptoms

Delay exercise if glucose is < mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

Fixed Snack: Provide grams of carbohydrate prior to physical activity if glucose < mg/dL

Added Carbs: If glucose is < mg/dL (120 DEFAULT) give grams of carbohydrates (15 DEFAULT)

TEMPORARY BASAL RATE as indicated above

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below mg/dL (below 70 mg/dL DEFAULT) or below mg/dL before/during exercise (DEFAULT is < 120 mg/dl).

1. If student is awake and able to swallow give grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.

 School nurse/parent may change amount given

2. Check blood glucose every 15 minutes and re-treat until glucose > mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)

Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

Glucagon Emergency Kit by IM injection Gvoke by SC injection Auto-Injection, Gvoke HypoPen

Dose: 0.5 mg or 1.0 mg

Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

Baqsimi Nasal Glucagon 3 mg

Name of Health Care Provider/Clinic:

Contact #:

Fax #:

Email Address (non-essential communication):

Other:

STUDENT LAST NAME:

FIRST NAME:

DOB:

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over _____ mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
 - a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)
 - Consider insulin correction dose. Refer to the “Correction Dose” Section 6.A-B. for designated times correction insulin may be given.
 - *Can return to class and PE unless symptomatic*
 - Recheck glucose and ketones in 2 hours
 - b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
 - Contact parents/guardian or, if unavailable, healthcare provider
 - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the “Blood Glucose Correction Dose” Section 6.A-B
 - If using insulin pump change infusion site/cartridge or use injections until dismissal.
 - No physical activity until ketones have cleared
 - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
 - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

Send student’s diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student’s Physician/Health Care Provider: _____ Date: _____

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____ to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child’s physician/health care provider.

Acknowledged and received by:

Student’s Parent/Guardian: _____ Date: _____

Acknowledged and received by:

School Nurse or Designee: _____ Date: _____



MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____
School: _____ Grade: _____ Teacher: _____ School Year: _____
List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____
Parent Name: _____ Phone Number: _____

PHYSICIAN AUTHORIZATION (To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____
Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____
Date of Authorization: _____ Begin/End Dates: _____

Special Instructions for Administration and Storage of Medication:

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes No

If yes, please provide recommended administration time(s): _____

Is the medication a controlled substance? Yes No Does medication require refrigeration? Yes No

Special Instructions or Storage: _____

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)

Provider Name: _____ Provider Signature: _____

Phone Number: _____ Date: _____

PARENT AUTHORIZATION (To be completed by parent/guardian)

- I authorize the delegated personnel the task of assisting my child with medication administration.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Only medication prescribed and provided by the United States will be administered in school.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Administration consent form must be completed and signed by physician, parent, or legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- Only students with written authorization from their physician and parents are allowed to self-carry medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Secondary Contact Number: _____ Date: _____



MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
(Nombre del Estudiante) (Fecha de Nacimiento)
Address: _____ City/State/Zip: _____
(Dirección) (Ciudad/estado/código postal)
School: _____ Grade: _____ Teacher: _____ School Year: _____
(Escuela) (Grado) (Maestro/a) (Año escolar)
List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____
(Alergia/Reacción Conocida a Medicamentos) (Altura) (Peso)
Parent Name: _____ Phone Number: _____
(Nombre del Padre) (Número de Teléfono)

PHYSICIAN AUTHORIZATION (To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____
Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____
Date of Authorization: _____ Begin/End Dates: _____
Special Instructions for Administration and Storage of Medication:
Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes No
If yes, please provide recommended administration time(s): _____
Is the medication a controlled substance? Yes No Does medication require refrigeration? Yes No
Special Instructions or Storage: _____
Potential Side Effects/Contraindications/Adverse Reactions: _____
Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)
Provider Name: _____ Provider Signature: _____
Phone Number: _____ Date: _____

AUTORIZACIÓN DE LOS PADRES (Para ser completado por el padre/tutor)

- Autorizo al personal delegado la tarea de asistir a mi hijo en la administración de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Sólo se administrarán en la escuela los medicamentos prescritos y proporcionados por los Estados Unidos.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____
(Nombre del Padre de Familia / Guardian) (Firma del Padre / Tutor)
Secondary Contact Number: _____ Date: _____
(Número de Contacto Secundario) (Fecha)