

## Notice to Families Regarding Medication Administration



Dear Parent/Guardian:

To protect your child's safety, the school licensed practical nurse (LPN) and/or Health Aide (as designated by the principal) will adhere to the following medication administration requirements. It is required that BOTH legal guardian AND physician signatures are on file before any prescription can be given.

Although this may cause some inconvenience, we believe these requirements are 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 LPN, Health Aide, or the school office.

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

- All Action/Care Plans will need to be submitted with a Medication Consent form.
- Medication Consent Form must be completed and signed by physician and parent/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.
- Parent/Legal Guardian must notify the school if a student's physician changes 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/legal guardian are allowed to self-carry emergency 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/legal guardian signs the consent form or picks up medication.
- The medication and the signed permission forms must be brought to the school by the parent/legal guardian and delivered to the campus clinic LPN or 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/legal 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 bring the refill to school promptly. Parents must bring refill of medication to the clinic. Can not be brought in by student.
- If your student is taken off medication, will no longer receive it at school, or if the prescription otherwise changes, a dated, written note with updated prescription information of such changes must be provided. 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 their designee if you have any questions. Thank you for your cooperation.

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.
- 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. No envíe resurtidos de medicamentos con el estudiante; los padres deben traerlos.
- 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.



# IDEA Public Schools Health Services Medical Practitioner Orders for Medical Treatment/Procedures

**Students Name:** \_\_\_\_\_ **Student's ID:** \_\_\_\_\_  
*(Número de estudiante)* *(Identificación del estudiante)*

**School:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
*(escuela)* *(Fecha de Nacimiento)* *(Grado)*

**MEDICAL PRACTITIONER STATEMENT:**

This student is currently under my medical supervision. He or she requires medical treatment during the school day as prescribed below. All procedures shall be followed as described until the date to discontinue as stated on this form, or until further notice. This form must be updated every school year unless discontinue date is prior to the next school year.

**Diagnosis:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Procedure** (include action, time, frequency, equipment, and special instructions) *Parent is responsible for supplying DME supplies to complete procedure:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Considerations** (include special instructions): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Daily Medications** (Medication Name, Dose, Route, Frequency): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date to discontinue procedure:** \_\_\_\_\_  **Discontinue at end of school year**

Medical Practitioner name/Credentials (print)      Medical practitioner signature      Date

Address      City, State, Zip

Office Phone Number      Fax Number



# 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.
- This Medication 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 emergency 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)*