

ADMINISTRATION OF MEDICATION TO STUDENTS

The board is committed to the inclusion of all students in the education program and recognizes that some students may need prescription and nonprescription medication to participate in their educational program.

Medication shall be administered when the student's parent or guardian (hereafter "parent") provides a signed and dated written statement requesting medication administration and the medication is in the original, labeled container, either as dispensed or in the manufacturer's container.

When administration of the medication requires ongoing professional health judgment, an individual health plan shall be developed by an authorized practitioner with the student and the student's parent. Students who have demonstrated competence in administering their own medications may self-administer their medication. A written statement by the student's parent shall be on file requesting co-administration of medication, when competence has been demonstrated. By law, students with asthma or other airway constricting diseases or students with a risk of anaphylaxis who use epinephrine auto-injectors may self-administer their medication upon the written approval of the student's parents and prescribing licensed health care professional regardless of competency.

Persons administering medication shall include authorized practitioners, such as, licensed registered nurses and physicians, and persons to whom authorized practitioners have delegated the administration of medication (who have successfully completed a medication administration course). A medication administration course and periodic update shall be conducted by a registered nurse or licensed pharmacist, and a record of course completion shall be maintained by the school.

A written medication administration record shall be on file including:

- date;
- student's name;
- prescriber or person authorizing administration;
- medication;
- medication dosage;
- administration time;
- administration method;
- signature and title of the person administering medication; and
- any unusual circumstances, actions, or omissions.

Medication shall be stored in a secured area unless an alternate provision is documented. Emergency protocols for medication-related reactions shall be posted. Medication information shall be confidential information as provided by law.

Approved	<u>8-16-93</u>	Reviewed	<u>11-14-11</u>	Revised	<u>1-11-16</u>
			1-11-16		2-22-16
			2-22-16		3-14-16

**AUTHORIZATION ASTHMA OR AIRWAY CONSTRICTING MEDICATION
SELF-ADMINISTRATION CONSENT FORM**

_____/_____/_____
Student's Name (Last), (First) (Middle) Birthday School Date

In order for a student to self-administer medication for asthma or any airway constricting disease:

- Parent/guardian provides signed, dated authorization for student medication self-administration.
- Physician (person licensed under chapter 148, 150, or 150A, physician, physician's assistant, advanced registered nurse practitioner, or other person licensed or registered to distribute or dispense a prescription drug or device in the course of professional practice in Iowa in accordance with section 147.107, or a person licensed by another state in a health field in which, under Iowa law, licensees in this state may legally prescribe drugs) provides written authorization containing:
 - purpose of the medication,
 - prescribed dosage,
 - times or;
 - special circumstances under which the medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container containing the student name, name of the medication, directions for use, and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, a student with asthma or other airway constricting disease may possess and use the student's medication while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, such as while in before-school or after-school care on school-operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by IOWA CODE § 280.16.

Medication	Dosage	Route	Time
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Purpose of Medication & Administration /Instructions

AUTHORIZATION-ASTHMA OR AIRWAY CONSTRICTING MEDICATION
SELF-ADMINISTRATION CONSENT FORM

Special Circumstances

_____/_____/_____
Discontinue/Re-Evaluate/
Follow-up Date

Prescriber's Signature

_____/_____/_____
Date

Prescriber's Address

Emergency Phone

- I request the above named student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or interfering with a student's self-administration of medication
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree to provide the school with back-up medication approved in this form.
- *(Student maintains self-administration record.) (Note: This bullet is recommended but not required.)*

Parent/Guardian Signature
(agreed to above statement)

_____/_____/_____
Date

Parent/Guardian Address

Home Phone

Business Phone

Self-Administration Authorization Additional Information

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION
OF PRESCRIPTION MEDICATION TO STUDENTS

_____/_____/_____
Student's Name (Last), (First), (Middle) Birthday School Date

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

Medication/Health Care Dosage Route Time at School

Administration instructions

Special Directives, Signs to Observe and Side Effects

_____/_____/_____
Discontinue/Re-Evaluate/Follow-up Date

Prescriber's Signature Date

Prescriber's Address Emergency Phone

I request the above named student carry medication at school and school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION
OF PRESCRIPTION MEDICATION TO STUDENTS

Parent's Signature

_____/_____/_____
Date

Parent's Address

Home Phone

Additional Information

Business Phone

Authorization Form