THE RHOADES SCHOOL

MEDICATION POLICY

California Ed Code 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school or maintain or improve the potential for education and learning.

NON-PRESCRIPTION (OVER-THE-COUNTER) AND SHORT TERM PRESCRIPTION MEDICATION

Prescription medication must be prescribed by a Recognized Medical Authority*. Parent/guardian must complete the form on the next page requesting school personnel administer the medication with the following information:

- Student's name (prescription medication must be for the student only, no other name will be accepted)
- Name of prescription/medication
- Detailed information on the dosage
- Frequency and time of each dose
- Length of use
- The circumstances under which the medication should be administered
- For prescription medication, the prescribing authority's* name
- Prescription medication must be properly labeled by the California pharmacy
- Clearly describe potential adverse reactions.

Non-prescription medication needs to be supplied in the original sealed container labeled legibly with the student's name.

EMERGENCY MEDICATIONS (I.E. INHALER, EPI-PEN & INSULIN) AND LONG TERM PRESCRIPTION MEDICATION

Parents/guardians of any student who has been prescribed life-saving emergency medication or long term prescription medication (more than 4 weeks) must submit documentation from the student's physician. Additionally, any student who has been prescribed an inhaler and/or Epi-Pen must submit an allergy and/or asthma action plan (this form may be obtained from your child's physician). Emergency medications must be properly labeled by the California pharmacy.

MEDICATION FOR FIELD TRIPS

These same procedures will be followed for any medications administered on a field trip. Medications must be stored in a labeled zip-lock bag and delivered to the school within 24 hours of the trip. **Students with life-saving emergency medications must travel with teachers who are trained to administer the medication.**

*Physician, Physician Assistant, or Nurse Practitioner licensed to practice in the State of California.

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MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully in order for school personnel to administer the required medication. A new Medication Administration Authorization Form must be completed at the beginning of each school year and each time there is a change in dosage or time of administration of a medication. **Form must be completed by a parent/guardian.**

- **Non-prescription** medication must be in the original sealed container with the label intact and legible.
- **Prescription** medication must be in the original sealed container labeled by the pharmacist or prescriber.
- **Life-saving emergency (i.e. Epi-Pen, inhaler, insulin) medication** must be accompanied by a physician's note and an allergy/asthma action plan.
- **Medications for field trips** should be delivered to the school within 24 hours from the trip. Medications should be in the original sealed container with the label intact and legible and put in a zip-lock bag with this form included.

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is administered: _____

Medication Name: _____ Dose: _____

Route (i.e. orally, injection, applied on skin, etc.): _____

Time/frequency of administration: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from (Month/Day/Year): _____ to _____

PARENT/GUARDIAN AUTHORIZATION:

I/we request designated school personnel to administer the medication stated above. I/we certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/we understand that at the end of the school year, medication must be picked up by the last day of school, otherwise it will be discarded. I/we will comply with the school's policies and procedures. I/we will notify the school if there are changes in my/our child's health status, changes in medication or change in health care provider.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____