MEDICATIONS AT SCHOOL

Introduction

The goal of the school system regarding the administration of medication during school hours is to assist students in maintaining an optimal state of wellness, thus enhancing the educational experience. **These guidelines refer to both prescription and over-the-counter medications.**

The parent/guardian should treat minor illness at home. For example, a student with a cold severe enough to require frequent medication should remain at home.

It is the policy of the Mobile County Public School System to administer the student's medication as prescribed by their physician. The local school district encourages parents to give the student their medication at home whenever possible. For example, when a student has medication ordered daily, the medication should be given at home. Medication prescribed three times a day should be given at home, just before leaving for school, upon returning home in the afternoon, and at bedtime. The only exception to this schedule is medication that must be given before or with meals. Contact the school nurse if there are other special conditions that should be cleared by Health Services.

The following requirements provide school personnel, parent/guardians, students and health professionals with the guidance necessary to provide safe and proper assistance with medication in schools.

Parent's Responsibility

The parent/guardian and physician must sign the Alabama State Department of Education **School Medication Prescriber/Parent Authorization** form granting permission for a child to receive prescription medication at school.

The parent/guardian must provide the school with medication is in a correctly labeled prescription bottle container (which includes the student's name, prescribers name, name of medication, strength, dosage, time interval, route and date of the drugs discontinuation when applicable). Do not **UNDER ANY CIRCUMSTANCES** send medication to school in a zip lock bag or container other than the original container. This medication **will not be given** and parents will be contacted to pick up the medication.

The parent/guardian must provide the school with a new signed prescriber/parent authorization form at the beginning of each school year and/or before any prescription medication can be given at school. This consent form authorizes school personnel to assist students with medication. If the medication order is changed during the school year (e.g., change in dosage), an additional prescriber authorization/order is necessary.

The parent/guardian or the designated responsible adult must deliver all medication to the school nurse or other school personnel as designated by the principal. The parent/guardian shall pick up the students unused medication (when the medicine is completed, out of date, or at the end of the school year). The school nurse or designated school personnel will destroy medications not picked up by the parent/guardian in a timely manner.

The parent/guardian shall provide nonprescription medication in the original, unopened, sealed container of the drug, identifying the medication and the entire manufacturer's labeling plus the students name (written legibly on the container). Please provide medication, such as Tylenol, in the smallest container available. The ALSDE **School Medication Prescriber/parent Authorization** form is required for school administration of over the counter medications.

School's Responsibility

The registered school nurse with the assistance of the school principal identifies the appropriate individual who shall ensure the right student gets the right medication, in the right dosage, by the right route, at the right time, for the right reason, and has documented appropriately, accurately, and in a timely manner.

Designated school personnel shall receive school-specific and student specific training from the delegated registered school nurse prior to assisting students with medication in a safe and private setting (i.e., an area free of distractions and disruptions).

The delegating registered school nurse must evaluate and approve all the over-the-counter medicines and parent instructions. The delegating registered school nurse will determine if over-the-counter medication is appropriate and whether a physician's order is necessary. In 2004, the Alabama Board of Nursing issued a declaratory ruling stating that "a school nurse may administer over-the counter medication without a physician's authorization". Therefore, only parent/guardian signed permission is required for assistance with over-the-counter medication.

In the event of an allergic reaction or an emergency involving medication, the school will handle the problem as any other medical emergency.

If you child has a chronic illness that requires prescription medications, both the physician and parent/guardian signatures are required on the Alabama State Department of Education **School Medication Prescriber/Parent Authorization** form.

The school personnel will administer sample medication provided from a physician only if it is in an original, unopened, sealed, properly labeled container and according to written directions from the physician.

School personnel will refuse to administer medication when there is **any** discrepancy (i.e., label different from instructions or contents, label is unclear or label is torn). This medication **will not be given** until clarification is obtained.

The school personnel and parent/guardian must count all controlled drugs upon delivery and document the number of tablets or capsules delivered to the school.

The parent/guardian shall give the first dose of a new medication or a change in dosage (increase or decrease) of current medication at home, with the exception of emergency medications (e.g., Epipen injections) in case of a possible allergic reaction.

Student's Responsibility

Students must not deliver medications to the school.

Students must have a signed order/authorization from a licensed prescriber and signed parent/guardian permission to self-medicate and carry medications on their person (i.e., Epipen, asthma inhalers, insulin).

Students who have met the criteria to self-medicate will be able to identify and select the appropriate mediation, know the frequency and purpose of the medication ordered, and follow the school's self-administration procedures (e.g., safety and security precautions, proper labeling).

Students will notify their teacher/nurse at the onset of any distress or allergic reaction.

Questions and Answers Regarding Medication

Q. Why should parents bring student's medication to school?

A. The Mobile County Public School System does not want to place any child in a situation where they may be confronted for drugs. Some medications have a street value. When the parents bring the medication, this ensures no other child will tamper with the medication and decreases the value of abuse.

Q. Why can't my child keep his/her medication?

A. To protect all children from taking medication belonging to another child, no child may carry their own medication at school, unless they have been authorized by the physician, parent and nurse to self-medicate.

Q. Why can't I write on my child's prescription bottle?

A. Prescription bottles can get smeared and very difficult to read. It is never a good practice to write on a prescription bottle. This practice is also unsafe and may interfere or obstruct the ability to read the prescriber's original orders listed on the prescription bottle (i.e., student's name, name of medication, strength, dosage, time interval, route, and date of drug's discontinuation when applicable).

Q. Why can't the school provide and give medication for minor illness or pain?

A. The Board of Nursing specifically prohibits the nurse from stocking medication.

Q. What is the policy on herbal medications and food supplements?

A. Herbal medications and food supplements will not be given without a written order from a physician, parent authorization, verification that the products is safe to administer to children in the prescribed dosage and reasonable information regarding therapeutic and untoward effects.

Q. What is the policy on products containing aspirin?

A. Due to the increase incidence of Reyes' Syndrome in children, the school nurse will not give aspirin or products containing aspirin (Pepto-Bismol) without a physician's order.

More information concerning the medications at school can be found at www.abn.state.al.us

Revised 5/2013

Field Trip Procedures for Medication Administration

The goal of MCPSS is to facilitate students with special medical needs to be allowed to participate in all school activities. It is especially important to plan ahead for any student with a chronic health condition who may be going on a day field trip or overnight field trip as he/she may need medications given that he/she normally takes at home. The following criteria must be met:

If a student requires medication to be administered during a field trip the following procedure must be implemented:

- The student must have a completed **(SS417-A) ALSDE School Medication Prescriber/Parent Authorization** form on file in the first aid room. A copy of the form should accompany the student on the field trip as well as the students daily medication log (MARS).
- The principal's designee (trained in the ALSDE medication administration training) must accompany the student on the field trip unless the School Nurse or parent/guardian is going on the field trip.
- The medication must be kept safely with the principal's designee, medication assistant, in the original container with the pharmacy label intact.
- Medication that needs to be refrigerated must be kept in a small cooler with ice packs if a refrigerator is not available.
- The medication assistant will follow the universal medication precautions known as the Seven Rights of Medication Administration.
- On overnight field trips if OTC medications are needed, the ALSDE School Medication Prescriber/Parent Authorization form is required. The parent/guardian will also provide a sealed unopened bottle of medication.
- Documentation should be completed on the Student Medication Log (MARS) as soon as the medication is administered.
- If the trip extends overnight, Parents/Guardian are responsible to obtain another **ALSDE School Medication Prescriber/Parent Authorization Form** with specific instructions for the administration of the medication for the extended hours.

- If a student is incapable of self-administering his/her medication per the medication authorization form, a plan of action should be developed to assist in meeting the needs of the student. It is always recommended to encourage the parent/guardian to accompany the student on the field trips.
- If the parent/guardian cannot accompany the child on the field trip and the student is receiving nursing services at school then the principal or teacher must arrange for nursing services for the student while on the field trip. **Health Services should be notified at least two weeks before the date of the field trip.** If assistance is needed in the coordination of health services for the field trip, contact the School Nurse or office at 251 221-4292.

Return to School:

- The Medication Assistant will return medication, verify count with a second person, sign medication back in documenting with both signatures. Place medication back in locked medication cabinet or drawer.
- Return the Authorization for Medication/Treatment form and copy of MARS.

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( )_____-_____ **Fax:** ____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( )_____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ___/___/_____ **Phone:** ( )_____-_____

revised 5/2014

SS-417-A-1 **ALABAMA STATE DEPARTMENT OF EDUCATION** revised 5/2014

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR TRACHEOSTOMY CARE

School Year: ____ - ____

STUDENT INFORMATION

Student's Name _____ **School:** _____

Date of Birth: ____/____/____ **Age:** _____ **Grade:** _____ **Teacher:** _____

☐ **Known drug allergies/reactions If drug allergies, list:** _____ **Weight:** _____ **pounds**

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ **STOP DATE;** _____

Tracheostomy Tube Info.
Brand: _____ * Size: _____ Length: _____
Check all that apply: ☐ Cuff ☐ Non-cuff ☐ Trach Tapes to hold in place
If yes, location of replacement tube: _____
Student will have Emergency Kit/"Go Bag" at school daily.

Humidifier Type: _____
Required care: _____

Tracheostomy Suctioning Orders:

Suction machine: Set to _____ mm Hg ☐ Will remain at school ☐ Will travel with student back & forth from school
Recommended depth for suctioning: _____ mm
Irrigate with normal saline prior to suctioning? ☐ No ☐ Yes ☐ PRN only Describe circumstance for prn saline w/suctioning: ___
_____.
Written instructions for cleaning machine are to be provided by parent and/or healthcare provider and are to be included in student's Individualized Healthcare Plan.

Suction Technique: ☐ Clean ☐ Sterile Catheter Size: _____ Replace catheter: ☐ Each time suctioned ☐ End of one day

***Is student authorized to complete self-suctioning care?** ☐ Yes ☐ No
If "yes", I hereby affirm that this student has been instructed in proper self-care for suctioning technique.

Unless student is authorized to perform self-care, all tracheostomy suctioning care will be provided by the licensed school nurse.

Tracheostomy Tube Replacement Order in Event of Accidental Decannulation:

I hereby authorize the Licensed School Nurse, who has received training and successfully completed a return skill demonstration, to replace this student's tracheostomy tube with * same size or one size smaller

Is student's breathing assisted via ventilator? Yes ☐ No

If "yes", please provide the following:
Ventilator Brand: _____
Ventilator Settings: _____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I understand that additional parent/prescriber authorization forms will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedures. Procedure equipment and/or supplies must be registered with the licensed school nurse or his/her designee.

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

PARENTAL SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the *above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

SS-417-A-2

revised 5/2014

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR GASTROSTOMY TUBE CARE

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____ School Year _____

Any known drug allergies/reactions? ☐ Yes ☐ No If yes, please list: _____

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ STOP DATE: _____

Type Formula	Reason for Taking	Route: Enteral	Amount per feeding: _____ ml.	Frequency/Time(s)

RESIDUAL and FLUSH:

Check residual before feeding?	Flush before formula?	Flush before medication administered?
Yes ☐ No ☐	Yes ☐ _____ ml. No ☐	Yes ☐ _____ ml. No ☐
Notify prescriber if residual is greater than _____ ml? Yes ☐ No ☐	Flush after formula? Yes ☐ _____ ml. No ☐	Flush after medication is taken? Yes ☐ _____ ml. No ☐

STORAGE: Formula requires refrigeration after opening? Yes ☐ No ☐ Syringe/tubing stored in refrigeration? Yes ☐ No ☐

Self care is permitted and recommended for this student? *Yes ☐ No ☐

*If YES, I hereby affirm that this student has been instructed in the proper self-administration of the prescribed formula.

If' yes, do you recommend equipment, supplies and/or formula be kept "on person" by the student? *Yes ☐ No ☐

TYPE TUBE:

Mic-Key Button, Foley, Other:	Lumen size: _____ French	Length: _____ cm.	Balloon size: _____ ml.

Is student's stoma considered a mature stoma (At least 6-8 weeks post op)? Yes ☐ No ☐ *Date stoma considered mature: _____

- If the gastrostomy button or tube becomes dislodged after this date*, the school nurse, who has received specialized training approved by the Alabama Board of Nursing, will reinsert the gastrostomy tube/button or appropriate sized Foley catheter, tape it into place and contact the parent. The nurse will **NOT** inflate the tube/button or Foley balloon and will **NOT** provide an enteral feeding following reinsertion.
- If the gastrostomy button or tube becomes dislodged before this date*, the school nurse will immediately call the parent and prescriber. The parent or guardian will be responsible to pick up the student. The nurse will **NOT** attempt to reinsert the button. If bleeding from the stoma site, difficulty breathing or any change in status occurs 911 will be called immediately.

Treatment Order (Site Care, Dressing Change) : _____

(Attach additional sheet or use the back of this form if necessary)

_____

Printed Name of Licensed Healthcare Provider

Signature of Prescriber	Date	Phone	Fax

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to talk with the prescriber or pharmacist should a question come up about the procedure. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment and/or supplies must be registered with the school nurse, principal, or his/her designee. Formula must be in the original, unopened, sealed container and be properly labeled with the student's name.

Signature of Parent	Date	Phone	Cell

SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

Signature of Parent	Date	Phone	Cell

SS-417-A-3

revised 5/2014

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR CLEAN INTERMITTENT CATHETERIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ **School:** _____

Date of Birth: ___/___/___ **Age:** _____ **Grade** _____ **Teacher** _____

☐ **Known drug allergies** **If drug allergies, please list:** _____ **Weight:** _____ **pounds**

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider.)

START DATE: _____ **STOP DATE:** _____

Size of Catheter	Frequency/Time(s)	Measure & Record Output?	Location for Procedure:
_____ Fr.		☐ Yes ☐ No	☐ Nurse's office bathroom ☐ Other: (Describe) ☐ Classroom bathroom

Storage: Catheter will be discarded after each use, unless other instructions provided.

_____

Self care is permitted and recommended for this student? **Yes** ☐ **No** ☐

- If" **no"**, procedure is to be completed: ☐ By School Nurse ☐ With Assistance from School Nurse ☐ Supervised by School Nurse
- If" **yes"**, do you recommend equipment, supplies be kept "on person" by the student? Yes ☐ No ☐
  I hereby affirm that this student has been instructed in the proper technique for self-care related to his/her clean intermittent catheterization procedure. _____ (Initials)

Potential Contradictions/Adverse Reactions _____

_____

_____

Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____

Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment or supplies must be registered with the school nurse or his/her designee.

_____ _____ _____ _____

Signature of Parent **Date** **Phone** **Cell**

SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

_____ _____ _____ _____

Signature of Parent **Date** **Phone** **Cell**

SS-417-A-4

revised 5/2014

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR VAGUS NERVE STIMULATOR (VNS)

School Year: _____-_____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: ____/____/____ Grade _____ Teacher _____

☐ Known drug allergies/reactions If drug allergies, list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION
(To be completed by licensed healthcare provider)

START DATE: _____ STOP DATE: _____

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How& frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Repeat swipe X _____ if seizure activity does not cease after _____ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? ☐ Yes ☐ No
If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: _____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment or supplies must be registered with the school nurse or his/her designee.

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**