Appendix C

SAMPLE POLICY
MEDICATION ADMINISTRATION

Subject: Administering Medication to Students	**Adopted:**
Purpose: To establish a procedure for the administration of medication during school hours	**Revised:**

It shall be the policy of ___________________________that the administration of medication or supervision of self-medication to students during regular school hours should be discouraged unless necessary to maintain the student in school, or in the event of an emergency. The objective of any medication program is to promote self-responsibility. The school nurse or her/his designee can facilitate this process by providing information to the parent(s) or guardian and students on the process to be followed in administration of medication during school hours. The Board of Education will insure and indemnify personnel designated to administer or supervise the self-administration of medication when such personnel follow the policy and procedures put forth in this document. School personnel will not diagnose or treat illnesses.

The Illinois Department of Professional Regulation (IDPR) issued a legal opinion which allows a school employee to stand in the place of a parent or guardian in administration of medication or supervision of self-medication in the school setting. School employees who do not hold a valid IDPR license must receive training in the correct procedure to be used to administer medication and/or provide a specific treatment. This does not prohibit any school employee from administering emergency assistance to a student.

A certificated school nurse or registered nurse must manage the medication administration program following the *Recommended Guidelines for Medication Administration in Schools* developed by the Illinois Department Human Services IDHS) and the Illinois State Board of Education (ISBE), September 2000. A designated administrator will be responsible for medication administration or supervision of self-medication when a nurse is not available. Teachers or other employees cannot be required to administer medication or supervise self-medication although they may volunteer to do so.

Appendix D

Sample Authorization and Permission for Administration of Medication

____ ____/____/____ ________________ ____________
Student's Name (Last) (First) (Middle) Birthdate School Date

School medications and health care services are administered following these guidelines:

Physician/Prescriber signed dated authorization to administer the medication.
Parent signed, dated authorization to administer the medication.
The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
The medication label contains the student name, name of the medication, directions for use and date.
Annual renewal of authorization and immediate notification, in writing, of changes.

Physician Authorization:

Medication/Health Care Treatment ________ Dosage ________ Time to be administered ________

Intended effect of this medication ________ Expected side effects, if any ________

Other medications student is taking ________

May student self-administer medication under supervision of Health Service personnel or designate?
(*A student self-administration form must be completed*) (Please circle) YES / NO

Administration instructions

____

____

Discontinue/Re-Evaluate/Follow-up Date (circle one) ________

Prescriber's Signature ________ Date signed ________

Prescriber's Emergency Phone# ________ Prescriber's Address ________

Parental Authorization:

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize (name of School District) and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

______________________________	______________________________
Parent’s Signature	Home Phone
______________________________	______________________________
Parent’s Address	Business Phone
______________________________	
Date	

Additional Information

____

____

____

Appendix E

Sample Physician Request For Self-Administration of Medication

Name of Student	Birthdate
City Zip	Telephone Number

TO:

Principal:___________________________________

School: ___________________________________

The above named pupil has____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

Name of Medication	Type of Medication (Tablet, Liquid or Capsule)
Dosage	Time(s) to be given

Possible Side Affects

I certify that _______________________________has been instructed in the use and self-administration
(Name of Student)

of ____
(Name of Medication)

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

Phone Number of Physician	Signature of Physician Date
Address of Physician	Print Name of Physician Date

Appendix F
Sample Daily Medication Administration Record

Student: ______________________________ School Year: __________________ School __________________________________

Date of Birth: ______________ Teacher: _________________________ Diagnosis: _____________________________________

Medication, Route: ____ Date, Dose, Time: ___________________________________

Parent Name: ____Physician: _______________________________________

Parent Phone: ____Physician Address: __________________________________

Comments: ____Physician Phone: ___________________________________

Please put the time and your initials in appropriate box.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPTEMBER																															
OCTOBER																															
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DECEMBER																															
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JUNE																															
JULY																															

INITIAL	NAME
________	______________________________________
________	______________________________________
________	______________________________________
________	______________________________________

CODES

_ : Weekend
F : Field Trip
H : Holiday
D : Early Dismissal
A : Absent
W : Dose Withheld
N : None Available
O : No Show