Dispensing Medications in School

Medications should be administered to school children by parents whenever possible. When necessary persons designated by the school principal or District Nurse may administer medications to students under established conditions. Before any medication can be administered to a student in the Germantown School District, school personnel must receive written parental /legal guardianship consent. **Physician signature is required for all prescribed medications.**

For a child to take medication(s) during the school day, the following procedures must be followed:

1. Complete Medication Administration Form (Each medication requires a separate authorization form)

- Administration of Non-Prescription Medication Form (Buff)
  (Over the Counter Medication) only parent's consent and signature is required

- Administration of Prescription Medication Form (Green)
  Parent consent and physician authorization and signatures are required

- Self Administration of Medication Form (Blue) (Grades 6-12, see exception below)
  Parental consent will be required for all self administration of medication. In addition a physician signature will be required for all self administered **prescription** medication. Students will be allowed to carry emergency medications to include Epi-Pens or Asthma inhalers with parental and physician authorization and signature. Self Administration will be approved under the discretion of the school principal. Competency and safety of self use must be demonstrated prior to students self administering medication. **No controlled medication will be authorized for self administration.**

2. Parents or designated responsible adults are required to deliver medication to school if requesting the school to administer such. Students are prohibited from bringing medications on their person for delivery to school.

3. Parents are required to provide a maximum of a 4 week supply of medications if requesting medication administration at school. Therefore, periodic replenishment of medication supply will be needed.

4. Prescription medication must be in the original prescription container, clearly labeled with the name of the student, name and dosage of the medication, method of dispensation, time of day to be given, name of physician, date issued, pharmacy name, address, and phone number.

5. Over-the-counter medications must in original bottle or packaging. It will ***NOT*** be dispensed without written permission by the student's parent/guardian and the instruction. If the dose requested is other than the recommended therapeutic dose, physician documentation will be required.

6. Students authorized for self administration are restricted to having only a 1 day supply of medication on their person. Any Student transferring medication to another student will be subject to disciplinary action.

7. Parent or designated adult are to pick up remaining medications at the end of the school year. If medications have not been picked up by the last day of school, the medications left will be properly discarded.

GERMANTOWN SCHOOL DISTRICT
PARENTAL REQUEST FOR
ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Date: _____ **School:** _____

_____ is in need of medication during school. I hereby give permission to school staff designated by the principal to administer the below listed medication (one medication per sheet). It is my understanding that medication will be administered under the general supervision of a district designated health care professional.

Parent/Guardian Initials _____

Name of Medication: _____ Reason for Medication: _____

Dosage: _____ Time of Administration: _____

How to be Given (i.e. with water, with food): _____

Physician: _____ Clinic: _____ Phone: _____

I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding medication administration.

Parent/Guardian Initials _____

I also give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.
Home Phone: _____ Work Phone: _____

Parent/Guardian Initials _____

I will notify the school in writing at the termination of this request for medication administration, or of any change in directions of administration. In the event that I revoke consent for medication administration or discontinuance due to physician orders, I understand that a new Parental Request for Administration of Medications would need to be completed to reinitiate this request.

Parent/Guardian Initials _____

All non-prescription medication will be supplied in its original manufactures container. The medication is to be delivered to the school office by parent or parent designated adult.

Parent/Guardian Initials _____

I understand that no medication will be administered by the school without full compliance of the above stated terms and conditions.

_____ _____

Parent Guardian Signature **Date**

GERMANTOWN SCHOOL DISTRICT
PARENTAL REQUEST FOR
ADMINISTRATION OF PRESCRIBED MEDICATION
(Physician Signature Required)

Date: _____ **School:** _____

_____ is in need of medication during school. I hereby give permission to school staff designated by the principal to administer the below listed medication (one medication per sheet). It is my understanding that medication will be administered under the general supervision of a district designated health care professional.

Parent/Guardian Initials _____

Name of Medication: _____ Reason for Medication: _____

Dosage: _____ Time of Administration: _____

How to be Given (i.e. with water, with food): _____

Physician: _____ Clinic: _____ Phone: _____

I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding medication administration.

Parent/Guardian Initials _____

I also give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.
Home Phone: _____ Work Phone: _____

Parent/Guardian Initials _____

I will notify the school in writing at the termination of request for medication administration, or of any change in directions of administration. In the event that I revoke consent for medication administration or discontinuance due to physician orders, I understand that a new Parental Request for Administration of Medications would need to be completed and signed by physician to reinitiate this request.

Parent/Guardian Initials _____

I agree to supply the school with no more than a 4 week supply of medication. (Medication is to be delivered to the school office by parent or parent designated adult only)

Parent/Guardian Initials _____

Prescription medication will be supplied in a pharmacy labeled container. The label will have the child's name, drug name, dosage, and how often to be taken. Also, the name of the prescribing physician will be on the label, along with the pharmacy name and phone number.

Parent/Guardian Initials _____

I understand that I cannot send prescription medications to school with my child. The parent, or a responsible adult designated by parent, is expected to deliver any necessary medications to their child's school. An exception to this rule might be made only if the parent has requested approval for student self-administration of medication and the request has been approved by the building principal.

Parent/Guardian Initials _____

I understand that no medication will be administered by the school without full compliance of the above stated terms and conditions. **(Physician signature is required for all prescribed medication)**

_____ _____
Parent Guardian Signature **Date**

_____ _____
Physician Signature **Date**

GERMANTOWN SCHOOL DISTRICT
PARENTAL CONSENT FOR
SELF ADMINSTRATION OF MEDICATION
(Physician Signature Required for all Prescribed Medications)

Date: _____ **School:** _____

_____ is in need of medication during school hours. I hereby give permission for my child to self administer the below listed medication. (Please use one sheet per medication).

Name of Medication: _____ (Please circle) Prescription / Non-Prescription

Reason for Medication: _____

Dosage: _____ Time of Administration: _____

How to be Given (i.e. with water, with food): _____

Physician: _____ Clinic: _____

Physician Phone: _____ Fax _____

I also give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding self medication administration.

Parent/Guardian Initials _____

I accept complete responsibility for my child's self administration of medication and release the District from any liability. I understand that my child will be held responsible for the proper use of medications carried on his/her person for self-administration purposes. Appropriate disciplinary action will take place if any medication is transferred to another student by my child.

Parent/Guardian Initials_____

I understand that I cannot provide my child with more than a one day supply of medication. It is understood that the student will not be supervised during self-administration of the medication nor will the student be reminded of the medication schedule.

Parent/Guardian Initials_____

I understand that no medication will be self administered at school without full compliance of the above stated terms and conditions. **(Physician signature is required for all prescribed medication to include inhalers)**

_____ _____
Parent Guardian Signature **Date**

_____ _____
Physician Signature **Date**