MEDICATION PROCEDURE INFORMATION

RSPS Medication Administration Procedure must be followed in order for students to take medication during school hours and school sponsored events.

1. Parents must provide a written authorization for any medicine to be administered. This includes over-the-counter medicine (including cough drops) and prescription medicine.
2. The first dose of any new prescription must be given at home.
3. The parent/guardian is responsible for obtaining the written medication order. The attached RSPS Medication Administration Authorization Form is preferred. An authorized prescriber (physician, dentist, physician's assistant, nurse practitioner) must complete, sign and date the order form. Necessary information includes:

   - Name of student
   - Date of medication order
   - Name of medication
   - Dosage and strength of Medication
   - Date order expires (Check box if order valid for summer school)
   - Time and frequency of medication
   - Diagnosis (reason for administration of medication)
   - Authorized health care provider signature
   - Special instructions (including whether or not medication May be self-administered or carried by the student)

   Note: PRN medications should have the frequency of repeat doses clearly indicated on the order.

4. Occasionally students may need to self-administer/carry medication such as inhalers or emergency medication. A written medication order, signed by an authorized health care provider, that specifically states that the student may self-administer/carry medication, must be on file in the health room for any student who carries medication throughout the school day or during school sponsored events.
5. A new medication order is required for each new school year dated on or after July 1.
6. The medication should be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent. Students should not transport medication to or from school.
7. All medication must be properly labeled and consistent with the medication order. Pharmacy containers and labeling are preferred; *a second labeled container can be obtained by asking the pharmacist.* Parent should label over-the-counter medication. The following information must be on the label:

   - Name of student
   - Date of the medication order
   - Name of the medication
   - Route, time, and frequency of the Medication
   - Dosage and strength of the medication
   - Authorized health care provider name

8. The school nurse must approve the medication order before the first dose of medication can be administered at school.
9. The parent/guardian is responsible for submitting a new medication order form to the school each time there is a change of dose or time of administration or route of administration.
10. The parent must provide medication for as long as it is prescribed. All medication kept in the school will be stored in a locked area accessible only to authorized personnel.
11. Within one week after expiration of the effective date of physician's order, the parent/guardian must personally collect any unused portion of the medication. Medication not claimed within that period will be destroyed.
12. Expired medication cannot be given. The effective date of a medication is the earlier of either the pharmacy labeled expiration date or the manufactures expiration date.
13. Each student's confidentially will be maintained to the extent possible by school staff. At times, school personnel outside of the health services program may need to be made aware by health services staff that a student is receiving medication in order to monitor effectiveness, side effects, adverse reactions, or in response to other legitimate school related issues or responsibilities. Information will be shared on a need-to-know basis only.
14. Under no circumstances may any school staff administer any medication outside the procedures outlined in the health Services Medication Administration Procedure.

RESURRECTION ST. PAUL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid for school year_____

This form must be completed fully in order for school personnel to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication. Please label all medications with the student's name. At the end of the school year, a adult must pick up the medication, otherwise it will be discarded.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to school for review by the school nurse.
- The school nurse will call the prescriber, as allowed by HIPPA, if a question arises about the child or the child's medication.

Prescriber's Authorization

Name of Student:_____Date of Birth:_____ Grade:_____

Reason for Medication:_____

Medication Name:_____Strength:_____Dose:_____

Route:_____Time of administration:_____If PRN, frequency:_____

Relevant Side Effects of Medication:_____

Medication Order Expires (Specify):_____End of School Year **OR** _____
Month/Day/Year

Prescriber authorization for student to self carry/self administer emergency medication (initial): ☐
(Must be approved by the school nurse in accordance with State medication policy)

Prescriber's Name/Title (**Print**):_____

Telephone:_____FAX:_____

Prescriber's Signature:_____Date:_____

Parent Signature:_____Date:_____

Reviewed by school nurse:_____ Date:_____

Medication Expiration Date:_____

Prescriber's Address Stamp

Medication Administration Record

	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
Aug																															
Sep																															
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Mar																															
Apr																															
May																															
Jun																															

Codes: FT-field trip, X-school closed, A-absent, N-none available, DC-med discontinued, ED-early dismissal, R-refused, H-hold, O-omit

Name/Position/Initials

_____ _____

_____ _____

_____ _____

Attach Photo Here

Resurrection St. Paul Allergy Medication Order Form and Action Plan

Student Name_____D.O.B._____Gender____School Year_____

ALLERGY TO_____

Check all that apply: _____ingestion _____touch/contact _____sting/bite _____other (list)_____

TREATMENT

Symptoms:

Give checked medicine:**
** determined by physician authorizing treatment
Give Epinephrine first if both are checked

. If student has had contact with or touched allergen, but **no** symptoms (wash area with soap and water and observe for symptoms)		___Epinephrine ___Antihistamine
. If allergen has been ingested, but **no** symptoms		___Epinephrine ___Antihistamine
. Skin	Hives, itchy rash, swelling of face or extremities	___Epinephrine ___Antihistamine
. Mouth	Itching, tingling, **swelling of lips, tongue, mouth**	___Epinephrine ___Antihistamine
. Gut	Nausea, abdominal cramps, vomiting, diarrhea	___Epinephrine ___Antihistamine
. Throat	**Tightening of throat, hacking cough, voice changes**	___Epinephrine ___Antihistamine
. Lung	**Shortness of breath, repetitive coughing, wheezing**	___Epinephrine ___Antihistamine
. Heart	**Weak pulse, lightheaded, pale, blueness, fainting**	___Epinephrine ___Antihistamine
. If reaction is progressing (if two or more of the above areas affected), give		___Epinephrine ___Antihistamine

MEDICATION

Epinephrine: inject intramuscularly (check one)

____Epinephrine auto-injector 0.15 mg **____Epinephrine auto-injector 0.30 mg**

Antihistamine: give_____
Medication/strength/dose/route/frequency

Other: give_____
Medication/strength/dose/route/frequency

Check all that apply:

____Student requires additional epinephrine auto-injector in the classroom

____Student may carry epinephrine auto-injector in backpack

____Student requires special seating

____Student may carry auto-injector (after appropriate training)

____Student may self-administer auto-injector

EMERGENCY CONTACTS

Name/Relationship	Phone Numbers	
_____	_____	_____
_____	_____	_____

Provider's signature_____ **Printed name or stamp**_____ **Date**_____

Providers Phone number_____ **Parent Signature**_____ **Date**_____

(Prescriber Address Stamp)

Once epinephrine is used, call 911. Take the used auto-injector with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

EpiPen® and EpiPen® Jr. Directions

1. Pull off blue safety release.

2. Swing the pen and firmly push orange tip against outer thigh
So it "clicks."

4. Hold in place on thigh and count slowly to 3 to deliver drug.

5. Remove the EpiPen® unit and massage the injection area for seconds.

6. Seek medical attention.

Auvi-Q and Allerject Directions

1. Pull off red safety guard.
2. Place black end against outer thigh.
3. Then press firmly and hold in place for 5 seconds.
4. Remove from the thigh and massage the injection area for 10 seconds.
5. Seek medical attention.

Oral medication administration

Medication	Dose	Date	Time	Symptoms	Signature

Epinephrine administration

Medication	Dose/Site L/R	Date	Time	Symptoms	Signature

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