D-153

P-CDOP

**ADMINISTRATION OF MEDICATION**

The purpose of administering medication at school is to help students maintain a state of health sufficient for their academic learning and faith development. All schools shall develop clear procedures for the administration of medication.

Adopted 7/2018

Reviewed 6/2020, 7/2021, 7/2022

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AR-OCS

**ADMINISTRATION OF MEDICATION**

1. The school administration shall retain the right to decline to allow a particular medication to be administered by school staff.
2. All prescription and non-prescription (over-the-counter) medications require written authorization from the student’s health care provider (licensed to prescribe the medication) as well as written parental consent. A sample medication authorization form is included in the appendix.
3. The written parental request and health care provider’s authorization shall be valid only during the school year in which they are submitted, and must be renewed each subsequent school year.
4. The school may allow, on a case-by-case basis, the parent or other adult family member to directly give the student the medication at school as if they were doing so at home.
5. Any medication for a student must be in an original, properly labeled container, either labeled by the pharmacy with the name of the student, name of the medication, dosage and instructions, name of the pharmacist, and pharmacy contact information, or in the case of over-the-counter medications, labeled by the retailer with the name of the medication and suggested dosage, with the student’s name affixed to the container.
6. All medications shall be stored in a locked drawer or cabinet. Controlled substances must be stored in a locked cabinet that is securely affixed to the wall or floor.
7. Medications that require refrigeration shall be stored in a locked refrigerator separate from food products.
8. The school shall keep a log for each student of all medication administered at school, including the date, time, and initials of the staff member administering the medication. A sample form for this purpose is included in the appendix.
9. As required by state law, students may self carry and self-administer drugs for the treatment of asthma, diabetes, or serious allergies, provided that the parent has submitted their consent in writing as well as a written authorization from the student’s physician. The authorization from the student’s physician shall include the student’s name, the name and purpose of the medication and/or epinephrine auto-injector, the prescribed dosage, and the time or circumstances under which the medication or epinephrine auto-injector is to be used. The school reserves the right to restrict the self carry and self administration of medication for asthma, diabetes, or serious allergies to certain grade levels and/or ages of students.
10. Only a school nurse or other staff member designated by the school administration shall be permitted to administer medications to students.
11. Students will be subject to disciplinary action if they violate the school’s medication policies and/or procedures.
12. Unused medications will be returned to the family at the conclusion of the school year, when they withdraw from the school, or when the prescribed medication period concludes, whichever is sooner.

Adopted 7/2018

Reviewed 6/2020, 7/2021, 7/2022

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**ADMINISTRATION OF MEDICATION—APPENDIX**

School Medication Authorization Form

*To be completed by the student’s parent/guardian. A new form must be completed each school year. Please complete one form per medication. Medications must be brought to the school office in the original container.*

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To be completed by the student’s physician.*

Physician’s Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time medication is to be administered at school or under what circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescription Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Order Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discontinuation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected Side Effects (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Parents must also complete the next page***

**For all parents/guardians:**

By signing below, I agree 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and its employees and agents, on my behalf, 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 \_\_\_\_\_\_\_\_\_\_\_\_), lawfully prescribed medication in the manner described above, or over-the-counter medication that has been brought in by the student in the manner indicated on the container.

I acknowledge that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ does not have a school nurse. I agree to indemnify and hold harmless \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and its employees and agents against any and all claims, except a claim based on willful and wanton misconduct, arising out of the administration or the child’s self-administration of medication.

If you agree, please initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian

**For parents/guardians of students who need to carry asthma or diabetes medication or an epinephrine auto-injector:**

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and its employees and agents, to allow my child to possess and use his/her asthma or diabetes medication and/or epinephrine auto-injector while in school. Illinois law requires \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton misconduct, as a result of any injury arising from a student’s self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree, please initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian

**All parents must sign below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name Printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Date Signature/Date

Medication Administration Record

|  |
| --- |
| Student Name: Birthdate: Grade Level:Name of Medication: Dosage:School Year:Staff Member(s) Dispersing Medication: |
| *The staff member administering medication shall enter the time and their initials in the appropriate box(es) below.* |
| **Month** | **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.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Sept.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Oct.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Nov.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Dec.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Jan.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Feb.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Mar.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Apr.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **May** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Jun.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Name of Staff Member Initials**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ | **Codes**X = Non student attendance day or weekendA = Student absentD = Early dismissal (student left school for scheduled med time)N = No medication available (parents notified)O = Administration of medication omittedR = Student refusal or no show |