Goddard School District Medication Policy
Diabetic Flow Sheet

I authorize Goddard Schools (USD 265) Administration, Teacher or School Nurse to share information with

Dr. _____ .

Parent Signature: _____ Date: _____

Prescription Medication: It is ideal that all prescribed medications be given by the parent before or after school. However, with a written Physician order, also signed by the parent, a prescribed medication may be given at school by the school nurse or nurse designee. The parent/guardian must have given the initial dose of medication to the child to assure there will be no adverse reaction. The prescription medication must be brought to the school in the original prescription container and parent must ensure the label information contains:

*Name of the student *Name of the medication *Date the prescription was filled
*Prescribing physician *Medication dose/frequency/route *Expiration date

Non-Prescription Medication: Over the counter medications may be administered at school with written parental permission. The medication must be in the original container and the following written instructions must be provided to the nurse/designee:

*Name of the student *Name of the medication
*Dosage-how many they can take *Frequency-how often they can have it
*Reason for the medication *Expiration Date is verified

School employees who administer the medication in accordance with authorized physician instructions/or parent/guardian instructions and BOE policy shall not be liable for damages resulting from adverse reactions. IN the event of adverse reaction, the student will be treated according to standard emergency care guidelines.

Request to Administer Medication at School:

Student Name: _____ **Teacher**: _____ **Grade:** _____

School: ❒ Apollo ❒ Clark Davidson ❒ Earhart ❒ Explorer ❒ Oak Street ❒ Challenger ❒ Discovery
❒ Robert Goddard MS ❒ Eisenhower MS ❒ Goddard HS ❒ Eisenhower HS ❒ Goddard Academy

Medication Name: _____

Diagnosis/Reason for taking the Medication: _____

Directions: Dose:_____ Frequency: _____
(how many) (how often)

Duration of Treatment: ❒ Current School year ❒ Other: _____

Physician Signature: _____ Date: _____
(Required for prescription meds)

Printed Name: _____

Physician Phone Number: _____ Fax Number: _____

Parent Signature: _____ Date: _____
(Required for prescription and non-prescription medications)

Diabetic Flow Sheet

Student Name: _____

Diabetic Care Plan

Date	Time	BS	Action Taken	Date	Time	BS	Action Taken	Date	Time	BS	Action Taken

Supervising RN: _____ Initials: _____ Date: _____

Delegated Person: _____ Initials: _____ Date: _____

Delegated Person: _____ Initials: _____ Date: _____