JGFGB Supervision of Medications

The supervision of oral medications shall be in strict compliance with the rules and regulations of the board as carried out by district personnel.

~~**JGFGB-R** Supervision of Medications~~

Diagnosis and treatment of illness and the prescribing of drugs and medicines are not the responsibility of the public schools and are not to be practiced by any school personnel, including school nurses, unless authorized ~~hereunder~~. ~~School personnel are advised that the Nurse Practice Act K.S.A. 65-1113 et seq., as amended, makes it illegal for school nurses to administer medications and treatment that have not been prescribed by a medical person authorized to prescribe medication. The law under this statute also prohibits any acts of diagnosis.~~

~~It is the policy of the board that the public school should not provide students with aspirin or any other medication. The decision as to whether aspirin is needed is a form of diagnosis, and the dispensing of this medication is a form of treatment. Unauthorized administration of aspirin or other unprescribed medications shall not be practiced by any school personnel, including school nurses.~~

In certain explained circumstances when medication is necessary in order that the student remain in school, the school may cooperate with parents in the supervision of medication that the student will use. ~~; but~~ However, the medical person authorized to prescribe medication or the parent if it is a non-prescription medication must send a written order to the building administrator who may supervise the administration of the medication or treatment. ~~, and~~ The parents must submit a written request to the building administrator requesting the school's cooperation in such supervision and releasing the school district and personnel from liability.

~~Under the following rules, the supervision of medications by school personnel, including school nurses, is authorized:~~

School personnel shall not be required to be custodians of any medication except as required by a written order of a licensed medical person~~;~~ or in the case of nonprescription medication when requested in writing by the parents.

The medication shall be examined by the school employee administering ~~the medication~~ it to determine ~~in his judgment~~ that it appears to be in the original container, to be properly labeled and to be properly authorized by the written order of a licensed medical person. Two containers, one for home and one for school, should be requested from the pharmacist. ~~Only oral medications should be administered except~~

~~in emergency situations. The following health care providers, R.N., physician or dentist should be responsible for the overall administration of all medication in schools, and may delegate this to a LPN or unlicensed staff member after receipt of the medication and initial assessment.~~

Any changes in type of drugs, dosage and/or time of administration should be accompanied by ~~new~~ updated physician and parent permission signatures and a newly labeled pharmacy container.

~~In the K-12 facility all prescription~~ All medication maintained in the school setting should be kept in a locked container. This includes medication requiring refrigeration.

In certain circumstances the lawful custodian and the school nurse may agree to allow the pupil to carry his/her own inhaler as described below.

Students in grades 6-12 will be permitted to self-carry an inhaler(s) only as deemed necessary provided all the following criteria are met.

1) Completion of all proper forms.
   A) Permission for Medication to be Administered at School
   B) Authorization for Self-Medication at School – Inhaler Usage
   C) Self-Medication Assessment

2) School nurse and designated personnel are informed and agree that the student is capable/responsible of adhering to the self-medication policy.

This privilege may be at any time denied a student, at which time the inhaler medication would be kept in the school health room at all times and would be administered by the designated staff members.

Medications should be inventoried every semester ~~by a licensed health professional (registered nurse, licensed practical nurse, physician, pharmacist).~~ Out-of-date stock should be returned to parent or destroyed.

In the K-8 facility over-the-counter medications should not be maintained on any school premises, including athletic areas, unless ~~a prescription is provided along with~~ written parent permission to administer is obtained. The medication will be locked and would be administered by the designated staff members.

In the 9-12 facility over-the-counter medications should not be maintained on any school premises, including athletic areas unless a parent permission form is on file in the health room.

The building administrator may choose to discontinue the administration of medication provided that ~~he has first notified~~ the parents or medical person are notified in advance of the date ~~of such discontinuance with the reasons therefor.~~ and the reasons for the discontinuance.

~~The administration of any such authorized medication shall be logged by the building administrator or his designee in the school's medical diary which shall be maintained for these purposes and filed by the administrator for future reference.~~

After medication is administered, students should be observed for possible reactions to the medication. This observation may occur at the site of administration or in the classroom as a part of the normal routine.

This policy shall be shared with all local physicians and dentists where practicable. Forms should also be made available to the health care providers in the community.

An individual record should be kept of each medication administered. The record should include student identification, date prescribed, name of medication, time and date(s) administered, signature of person administering and section for comments.

In the administration of medication, the school employee shall not be deemed to have assumed ~~to himself~~ any ~~other~~ legal responsibility other than acting as a duly authorized employee of the school district.

FORMS FOLLOW ON NEXT PAGE:

Renwick USD #267
Authorization for Self-Medication at School – Inhaler Usage
Self-Carry (grades 6-12 only)

Student Name _____ Grade _____

Physician Name_____ Physician phone_____

I request that my child be permitted to medicate himself/herself at school for the treatment of symptoms related to asthma or reactive airway conditions as authorized by myself and my child's physician. I request that my child be permitted to carry his/her inhaler medication with them. I understand my child will be responsible for knowing the location of the inhaler at all times-*school personnel will not be responsible*.

I have read the medication policy for Renwick USD #267. A request for Administration of Medication at School has been completed.

I certify that my child understands what symptoms will require the use of the inhaler, the correct dosage to be used and how to correctly administer the inhaler prescribed.

I have discussed the following conditions with my child:

1) My child agrees to immediately tell an adult when they are having breathing symptoms.
2) My child agrees to never share her/his inhaler with another person under any circumstance.
3) My child agrees to have his/her name written on the inhaler at all times.

Name of Medication

_____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Student Signature _____ Date _____

NOTE: This form must be accompanied by a Request for Administration of Medication at School form that is signed by both parent and physician. A Self-Medication Assessment form will be completed by the building nurse and student to ensure safety and understanding. If you have any questions, please contact your building nurse.

Parent Consent to Carry Over-the Counter Medication
(for grades 9-12 only)

I, _____, give permission for my child,
(Name of Parent/Guardian)

_____, to keep _____
(Name of Student) (Name of medication)

with him/her at all times throughout the current school year. I understand that medications such as narcotics, psychotics, and some other prescription medication may not be kept by students. If my child has a prescription for such medications, I will take proper measures to assure the medication and necessary forms are given to the Health Nurse in the Health Room. Should <u>any</u> student be in possession of <u>any</u> medication without the proper papers in place that student is then responsible for any consequences applied by the school administration.

Signature _____

Date _____

Renwick USD #267
Self-Medication Assessment

Student _____ School _____

D.O.B. _____ Age _____

Physical/Behavioral Limitations

_____

_____

Name of Medication _____

Self-Medication Criteria:

A. Student is capable of identifying individual medication. ( ) Yes ( ) No

Comments:

_____

_____

B. Student is knowledgeable of purpose of individual medication. ( ) Yes ( ) No

Comments:

_____

_____

C. Student is able to identify/associate specific symptom occurrence and need for medication administration. ( ) Yes ( ) No

Comments:

_____

_____

D. Student is capable/knowledgeable of medication dosage. ( ) Yes ( ) No

Comments:
_____
_____

E. Student is knowledgeable about method of medication administration. ( ) Yes ( ) No

Comments:
_____

F. Student is able to state side effects/adverse reactions to his medication. ( ) Yes ( ) No

Comments
:_____
_____

G. Student is knowledgeable of how to access assistance for self if needed in an emergency. ( ) Yes ( ) No

Comments:
_____
_____

H An individual Health Care Plan has been developed for the student which will monitor and evaluate student's health status. ( ) Yes ( ) No

Comments:
_____
_____

Based on Assessment:

( ) Student is not a candidate for self-medication program at this time.

( ) Student is a candidate for self-medication program with supervision.

( ) Student has successfully completed self-medication training and demonstration of self-administration.

Comments: _____
_____

Principal/Teacher notified: ( ) Yes ( ) No

Parent Signature _____ Date _____

Student Signature _____ Date _____

Nurse Signature _____ Date _____