Subject: Medications for Students
Effective Date: December 14, 2006
Approved By: Board of Directors
Policy: 5005.1

Any student who is required to take, during the regular school day, prescribed or over the counter medication, medical test, or treatment may be assisted by school personnel. Before a student receives assistance with the administration of prescription or over-the-counter medication, medical monitoring, or medical test, River Springs Charter School's policy requires:

1. A written statement from a parent or guardian that requests and authorizes the charter school to assist the student with the administration of medication, medical test, or treatment;
2. For prescription medication, medical test or treatment, a written statement from a physician that specifies the dosage, name of the prescribing physician, method of administration, and the time schedule for the administration of the medication;
3. For over-the-counter medication, a written statement from the parent or guardian that specifies the dosage, method of administration, and time schedule for the administration of the medication.

Prescription medication, medical test, or treatment containers must be labeled by a California pharmacist. The label must indicate the student's name, the name of the prescribing physician, time of administration, the circumstance(s) in which the medication is to be administered, dosage, expiration date, and the name and telephone number of the pharmacy. Over-the-counter medications shall be provided to the school site facilitator in the original container and packaging. The parent or guardian should personally deliver medication, medication utensil, medical test or treatment equipment or supplies to school or send the medication, utensils, equipment, or supplies with a designated adult identified and authorized by the parent or guardian in writing.

A pupil may carry and self-administer prescription inhaled asthma medication or auto-injectable epinephrine provided the following are provided to the school:

1. A written statement from the physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer inhaled asthma medication [or auto-inject able epinephrine], and
2. A written statement from the parent, foster parent, or guardian of the pupil consenting to the self-administration, providing a release for the school nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the medication, and releasing the school district and charter school from civil liability if the self-administering pupil suffers an adverse reaction by taking medication pursuant to this section.

At the conclusion of the school year, a parent, guardian or designated adult should take all remaining medication home. All medication not returned home will be disposed of.

IN SUMMARY:

1. All medication requires a written plan.
2. Prescription medication requires a doctor's instruction and signature.
3. School forms for doctor and parent instructions for medication are available in the office and on the River Springs Charter School website (www.Riverspringscharter.org).
4. Students MAY NOT transport or carry medications, whether over-the-counter or prescription (except self-administered prescription inhaled asthma medication and auto-injectable epinephrine).
5. Parents must take responsibility supplying the needed medications to the school.
6. The prescription bottle MUST match the doctor's orders.

MEDICATION AUTHORIZATION RECORD

This form must be completed by physician before any prescription or over-the-counter medications can be staff or self-administered at school. *__New orders__ are required each school year. *For __SEVERE Allergy SEVERE Asthma & Seizure__ please complete an __ACTION PLAN__. *__DIABETICS must__ have a diabetic medical management plan (DMMP) completed by physician.*

Student Name:_____ **Student DOB:** _____

School: ☐ River Springs Charter School ☐ Empire Springs Charter School
☐ Harbor Springs Charter School ☐ Citrus Springs Charter School

School Phone: _____ **School Fax:** _____

PHYSICIAN USE ONLY

1. MEDICATION

Dose: _____ Symptoms/Diagnosis: _____

☐Inhale Side Effects to Watch for: _____
☐Nasal
☐Topical
☐Other (i.e. Essential Oils)
☐If DAILY = Time(s) to be given: ___ ☐If AS NEEDED (prn) ~ Frequency Every___
☐**Self-Administered** ~ For asthma inhaler or epinephrine auto-injectors ONLY.

2. OVER THE COUNTER MEDICATION

Dose: _____ Symptoms/Diagnosis: _____

☐Oral
☐Inhale Side Effects to Watch for: _____
☐Nasal
☐Topical
☐Other (i.e. Essential Oils)
☐Food Supplement
☐If DAILY = Time(s) to be given: ___ ☐If AS NEEDED (prn) ~ Frequency Every ___
☐**Self-Administered** ~ For asthma inhaler or epinephrine auto-injectors ONLY.

Physician Signature:_____Date: _____
Physician Name:_____Phone: ( )_____
Address: _____

EMPIRE SPRINGS HARBOR SPRINGS RIVER SPRINGS CITRUS SPRINGS

Parent Request for Assistance with Medication at School and Authorization for RSCS Nurse to Communicate with Student's Physician

This form must be signed by Parent/Guardian, and be accompanied by **Medication Authorization Form**, before any prescription or over-the-counter medications can be staff or self-administered at school.

Student Name _____ **Student DOB** _____

School:
- O River Springs Charter School
- O Empire Springs Charter School
- O Harbor Springs Charter School
- O Citrus Springs Charter School

School Phone:_____
School Fax:_____

California Ed Code Section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for her/him by a physician, may be assisted by the school nurse or other designated person if the school district receives (1) a written statement from the physician detailing the method, amount and time schedules by which the medication should be taken (2) written statement from the parent or guardian indicating the desire that the school district assist the pupil in the matters described in the physician statement. It also states a release of the school district and personnel from civil liability related to any adverse reaction to self- administered medication. **Release of Liability and Agreement to Indemnify and Hold School District Harmless (must be completed)**. I/we hereby expressly release, hold harmless, and agree to indemnify and defend the River Springs Charter School and its Governing Board members, officers , employees, agents, representatives, independent contractors and insurers from all claims and liability for any personal injuries, death, or property damage that may be incurred by permitting the school to assist in the giving my child's medication. This release hold harmless an indemnification agreement shall remain in effect until the written notice to terminate the agreement is received and acknowledged in writing by the school site administrator. I/we understand this agreement and grant the school permission to assist my child with their prescribed medication.

I permit an authorized representative of River Springs Charter School to communicate directly with my child's physician, as may be necessary, regarding any questions that may arise with respect to the medication. I understand that school policies and procedures require that my child's medication be stored in a secure place, under the direction of an adult employee of the River Springs Charter School, and not carried on the person of my child, unless otherwise ordered by physician.

Parent/Guardian Print Name:_____

Parent/Guardian Signature:_____Date:_____

For ASTHMA INHALER/EPI-PENS Self-Administered only. I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that my child must **demonstrate competency to school nurse** and follow the rules and responsibility of carrying his/her medication. I also understand that a student may be subject to disciplinary action if the self- administered medication is used in any manner other than prescribed.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Medication Acceptance Check List

Student Name_____**Student DOB** _____

☐**Check Medication Authorization Record and Parent Request for Assistance Forms**

☐Student's Name/DOB
☐Medication Name
☐Dosage
☐Route (i.e. by mouth, inhaled, topical, nasal)
☐Time, *If as needed, intervals noted
☐ MD Signature/Date/Phone/Fax/Address
☐ Parents Signature and Student Signature if self-administer. Student meet with school nurse to determine student competency to self-administer.

☐**Check Medication Label against the Doctor's Orders/U.S. Pharmacy**
☐Student's name (not grandfather's or sisters)
☐Medication name
☐Dosage
☐Time
☐Expiration Date

DO NOT ACCEPT MEDICATIONS IF ABOVE AREAS NOT COMPLETE

Count the Medication:

Medication Name:_____	Quantity on Hand: _____ (+) Quantity Received: _____ (-) Quantity Returned: _____ (=) Total: _____

- Lock Medication in Health Office Cabinet or Refrigerator

Parent Signature_____ Date _____

Staff Signature _____ Date _____