**Subject:** Medications for Students
**Effective Date:** May 24, 2013
**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, Harbor 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 Harbor Springs Charter School website (www.harborspringscharter.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.

| Harbor Springs Charter School Medication Instruction Form | |
|---|---|
| Student Name: | Program: |
| Parent Name: | ES of Record: |
| Parent Phone: | ES Phone: |
| | |
| Prescription Medication | |
| Physician Name: | Physician Phone: |
| Physician Address: | |
| Medication Prescribed: | |
| Prescription Directions:<br><br>Physician's Signature: | |
| Over-the-Counter Medication | |
| Parent's Address: | |
| Medication Prescribed: | |
| Prescription Directions:<br><br>Parent's Signature: | |
| Designation of Adult Courier other than Parent | |
| As the parent, or guardian, of the above named student, I authorize the following adult to transport my child's medication to and from Harbor Springs Charter School along with this form. I understand this courier must be prepared show valid identification to school personnel.<br>Parent's Signature: | |
| Courier Name: | Courier Phone: |
| Courier Address: | |
| Acceptance | |

| Harbor Springs Charter School Employee accepting this form: |
| --- |
| By my signature below, I affirm that I have compared this form to the medication container to verify accuracy and that I have informed the appropriate staff members of this medication requirement for the student named above.<br>Employee Signature: |