

**Pittsville Public School District**

20\_\_\_\_-20\_\_\_\_ School Year

**Prescription Medication**

**Order and Administration and Authorization**

**Release and Indemnification Agreement**

Student:

Date of Birth:

Grade/Teacher:

**PART I—TO BE COMPLETED BY THE LICENSED HEALTHCARE PROVIDER (LHP – MD, DO, or Nurse Practitioner)**

List Medication allergies:  none

*Please administer the following medications according to the specifications indicated:*

Name <small>*include emergency medications</small>	Dose	Route	Time(s)	Reason for Use, Side Effects, &/or Special Instructions	End Date

**SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL\*must be ordered above\***

*Self-carry/self-administration of inhalers or EpiPen must be authorized by the prescriber and parent as well as approved by the school nurse after appropriate demonstration is observed.*

This student has demonstrated appropriate knowledge and competency and may self-carry/self-administer the following emergency medication(s):  EpiPen (as ordered)  Inhaler: \_\_\_\_\_

Ordering Provider Name (PRINT): \_\_\_\_\_ Phone: \_\_\_\_\_

Location: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART II—TO BE COMPLETED BY THE PARENT/GUARDIAN**

*I hereby request and authorize Pittsville Public School District (PPSD) principal-designated personnel to administer prescribed medication as directed by the licensed healthcare provider (LHP) indicated in Part I above. I agree to release, indemnify, and hold harmless PPSD and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided staff are following the physician's order as written in Part I. I have read the PPSD medication policy and protocol as outlined on the back of this form and assume the responsibilities as required.*

My child may self-carry and/or self-administer the prescribed emergency medication(s)  Yes  No Initials: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

**PART III—TO BE COMPLETED BY THE SCHOOL NURSE**

- Parts I and II above are complete (separate provider prescription may be attached)
  - Prescription medication in original container with the pharmacy label intact and readable
  - Prescription medication label and Healthcare Provider order are consistent
  - Student demonstrates appropriate knowledge and competency to self-carry/self administer designated medication
- Emergency medication location:  health office  locker  back-pack  N/A
- Entered into Skyward: initials \_\_\_\_\_ date \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Pittsville School District Medication Policy and Protocol

1. Prescription medication to be administered in school or during school-sponsored activities requires the written order from the prescribing licensed healthcare provider (LHP) and parent/guardian written consent.
2. Non-prescription medication requires parent/guardian written consent.
3. Non-prescription medication will require a written order from a LHP if needed to be given for more than 5 consecutive days
4. This parent /guardian is responsible for completing Part I and obtaining the LHP written order on Part II
5. A new Prescription Medication Authorization form is required:
  - at the beginning of each school year
  - with any new medication order
  - with any changes in current medication (i.e. dose, time, etc.)
6. Written communication of medication discontinuation is required from the parent/guardian.
7. Medication must be delivered to the school health office by the parent/guardian or adult designated in writing by the parent/guardian, otherwise, it will **not** be accepted.
8. All prescription medications must be in the original container with the pharmacy label intact and readable.
9. Physician samples must be appropriately labeled.
10. It is strongly recommended to administer the first dose of a new medication at home to observe student for any potential reactions
11. Parent/Guardian or adult designated by the parent/guardian in writing must collect any expired or unused prescription or non-prescription medications by the end of the school year or the medications will be destroyed.
12. Students may not self-administer controlled medications.
13. Licensed Healthcare Provider and parent/guardian consent are necessary to self-carry/self-administer emergency medications such as inhalers and EpiPens.
14. The student should report the use of their inhaler if he/she does not experience improvement in breathing
15. The student **MUST REPORT** the use of EpiPen; EMS (911) **will be** notified after the use of EpiPen regardless of symptoms.
16. The school registered nurse (RN) will call the prescriber, as allowed by Health Insurance Portability and Accountability Act (HIPAA), if any concern arises related to the medication prescribed.

Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_