I. DOCTOR'S ORDER—Medication to be given by the SCHOOL NURSE

(TO BE COMPLETED BY PHYSICIAN)

The following medication is to be administered to my patient, _____.

MEDICATION _____ DOSAGE / ROUTE _____

TIME TO BE GIVEN _____ LENGTH OF TREATMENT_____

SIGNIFICANT SIDE EFFECTS _____

DIAGNOSIS _____ _____

M.D. name (print

_____

_____

M.D. Signature Date

II. DOCTOR'S ORDER—Student "self administration" of medication

(TO BE COMPLETED BY PHYSICIAN)

The following medication is to be self-administered by my patient, _____. I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been instructed in the proper administration of the required medication.

MEDICATION _____ DOSAGE / ROUTE _____

TIME TO BE GIVEN _____ LENGTH OF TREATMENT_____

SIGNIFICANT SIDE EFFECTS _____

DIAGNOSIS _____ _____

M.D. name (print)

_____

_____

M.D. Signature Date

III. PARENT / GUARDIAN REQUEST AND RELEASE

I request for my child, _____, to receive (self-administer) the medication designated above. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the medication to my child. I hereby indemnify and hold harmless the Demarest Board of Education, its agents, and employees from any and all claims.

_____ _____

Date Parent / Guardian Signature

*** If at all possible, medication should be given at home.

*** This permission **MUST** be renewed annually.

DEMAREST PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Administration of Medication During School Hours

The Board shall not be responsible for the diagnosis and treatment of student illness. The Administration of prescribed oral medication should be avoided, but will be permitted when failure to take such medication would jeopardize the health of the student or the student would not be able to attend school if the medicine were not administered during school hours. Medication will be administered only after the following conditions have been met.

1. A written request must be completed and returned to the school nurse by the prescribing physician detailing the name of the medication, diagnosis, dosage, form, time of administration, duration of treatment, side effects, and ramifications of failure to medicate (***complete section of form: Physician's Authorization***).

2. A written request must be completed by the parent/guardian and returned to the school Nurse for administration of medication that are authorized by the physician (***complete section III of form: Parent/Guardian Authorization***) relieving the Board of Education and its employees of liability for administration of medication.

3. Permission may be granted to a student for self-administration of medication for asthma or other potentially life-threatening illnesses (i.e.: inhalers, Epi-pens, Glucagon, etc.) provided the Parent/Guardian and Physician's Authorizations are completed including written certification regarding the student's condition and that the student is capable and has been instructed in self-administration of the medication (***complete section II of form: Physician's Authorization).***

4. The district shall incur no liability as a result of an injury arising from the self-administration of medication by the student.

5. The medication must be brought to the school nurse in a container properly labeled with the physician's name, child's name, drug, dose schedule by prescribing physician or pharmacy. The nurse may verify prescribed medication with the physician.

6. Absolutely, **NO** <u>over the counter</u> medications (i.e.: Tylenol, Advil, Maalox, etc.) will be administered in school unless ordered by a physician and accompanied by the completed sections of the form (***complete section I and III***).

7. The school Physician will review the medication orders of the private physician.