HARDEMAN COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Please complete all information:

Student Name: _____ School: _____

Date of Birth: _____ Academic Year: _____

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis for which medication is given: _____
(*i.e. Behavioral, seizures, asthma, diabetes*)

Name of Medication: _____ Dosage: _____

Form (pill, liquid, inhaler): _____ Time to be given: _____

List significant side effects:

_____

Length of time medication is prescribed:

_____

[ ] *The Undersigned hereby verifies that the cooperation of school personnel in assisting with this medication is necessary in order to permit the student to maintain regular school attendance.*

[ ] *The Undersigned hereby verifies that the above student suffers from asthma and has been instructed in self-administration of the prescribed, metered dosage, asthma reliever-inhaler.*

Physician's Signature: _____ Date: _____

Physician's Name (print): _____ Telephone Number: _____

Fax Number: _____

I request that my child be allowed to take his/her medication as authorized by the physician and me. I understand that although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible for obtaining his/her medication. (Special needs students are exempt from this responsibility.)

In the case of the administration of prescribed, metered dosage, asthma inhaler:

[ ] I do not want my child to self-carry his/her asthma inhaler.

[ ] I want my child to self-carry his/her asthma inhaler.

I agree to indemnify and hold harmless HARDEMAN COUNTY SCHOOLS and its employees from claims relating to the possession of self-administration of asthma inhalers, and understand that HARDEMAN COUNTY SCHOOLS, its employees and agents shall incur no liability as a result of injury to a student or any other person as a result of possession of self-administration of asthma inhalers.

I also authorize the school's nurse to consult with the prescribing physician to clarify this medication order, or in the interest if the student's health, to discuss his/her response to the prescribed medication. All health information will be kept confidential.

Date: _____ Parent/Guardian Signature: _____ Telephone #: _____

Date Discontinued: _____

HARDEMAN COUNTY BOARD OF EDUCATION
MEDICATION POLICY

Parents should use every effort to have medication times set for time periods other than school hours. When this is not possible, trained school staff, may assist in the administration of medication during school hours, subject to the following rules:

1) All medication must be brought to the school by a responsible adult, so please do not send any medication with your child. Medication should be given to the appropriate designated school official, who will count and record the number or amount received witnessed by the depositor.

2) All medication must be brought to school in the original, pharmacy labeled container. The container shall display:
    a) Student's Name
    b) Prescription Number
    c) Medication Name and Dosage
    d) Administration Route or Other Directions
    e) Date
    f) Licensed Prescriber's Name
    g) Pharmacy Name, Address, and Phone Number

3) Over the counter drugs to include lotions, salves, and ointments, Tylenol, cough medicines, etc., shall:
    a) Require an order from a licensed prescriber.
    b) Medication must be provided in an unopened container with the manufacturer's original label with the ingredients listed. The student's name must be affixed to the container.

4) Medications must be kept under lock and in an area designated by the principal, and will be dispensed in the office except in certain special areas including CDC classes and disciplinary settings. Emergency medicines (i.e. asthma inhalers, EPI-Pens, etc.) may be kept by the student as deemed necessary by the parent.

5) Unused medication not picked up by the parent will be discarded after 14 days or at the end of the school year.

6) A Medication Administration Record is utilized on all students receiving medication at school. Only licensed nurses may make changes on this form.

7) A Medication Variance Report will be completed in the event of a medication error.