

## ADMINISTRATION OF MEDICATION TO STUDENTS

Students may be required to take prescription and/or over-the-counter medication during the school day. Medication shall be administered by the school nurse, or in the nurse's absence, by a person who has successfully completed an administration of medication course reviewed by the Board of Pharmacy Examiners. The course is conducted by a registered nurse or licensed pharmacist. A record of course completion will be maintained by the school district. All medication must be kept in a secured area of the nurse's office. The exception is for students who have demonstrated competence in administering their medication for asthma or other airway constricting illnesses. These students may possess and self-administer the required medication provided an annual self-administration of medication form is completed and on file in the health office.

Prescription medication will not be administered without the completed Medication Permission Form from the health care provider that includes parental signature. All prescription medication must be in the original container which is labeled by the pharmacy or the manufacturer, with the name of the child, name of the medication, the time of day when it is to be given, the dosage and the duration. When administration of the medication requires ongoing professional health judgment, an individual health plan will be developed by the licensed health personnel, the student, and the student's parents. A written record of the administration of medication procedure must be kept for each child receiving medication including; the date, student's name, prescriber or person authorizing the administration, the medication and its dosage, the name, signature and title of the person administering the medication, the time and method of administration, and any unusual circumstances, actions or omissions. Administration of medication records shall be kept confidential.

A limited selection of over-the-counter medications will be available and administered as needed for students in PreK-12 grades based on student self-assessment. Students who request over-the-counter medication must have written approval from their parent or guardian on file with the school nurse before the student can receive the non-prescribed medication. Annual written parent/guardian approval is required. Parent/guardian contact will be made by the person administering the medication prior to administration, to confirm dosage for students in PreK-6 grades. An administration log of over-the-counter medication will be maintained at each school. Emergency protocol for medication-related reactions will be in place.

The superintendent, in conjunction with the school nurse, shall be responsible for developing rules and regulations governing the administration of prescription and nonprescription medication, including emergency protocols, to students. Annually, each student shall be provided with the requirements for administration of medication at school.

Legal Reference: Iowa Code ch. 124 (2003).  
 281 I.A.C. 41.23.  
 657 I.A.C. 1.1(3).

Cross Reference:  
 506 Student Records  
 507 Student Health and Well-Being  
 603.3 Special Education  
 607.2 Student Health Services

Approved: January 11, 1993

Reviewed: June 10, 1996; March 14, 2005

Revised: February 10, 1997, August 14, 2000; June 14, 2004; April 14, 2008

# REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

I request that medication be given by the school nurse or qualified personnel to:

Name of Student \_\_\_\_\_

Medication \_\_\_\_\_

First dose                      Dose \_\_\_\_\_ mg                      Time \_\_\_\_\_

Second dose                      Dose \_\_\_\_\_ mg                      Time \_\_\_\_\_

Third dose                      Dose \_\_\_\_\_ mg                      Time \_\_\_\_\_

Length of time medication will be required: School Year \_\_\_\_\_ Other \_\_\_\_\_

For what purpose has medication been prescribed \_\_\_\_\_

Is the before school dose given at home \_\_\_\_\_ or school \_\_\_\_\_.

Additional instructions: \_\_\_\_\_

To comply with the Iowa Administrative Code Section 41.12 (11) entitled "Medication Administration", a physician's description of anticipated reactions of the student to the medication must be filed at the school. Please list any anticipated reactions: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Physician)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

**This completed sheet must be at your child's school before any medication will be given.**

# REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

I request that medication be given by the school nurse or qualified personnel to:

Name of Student \_\_\_\_\_

Medication \_\_\_\_\_

First dose                      Dose \_\_\_\_\_ mg                      Time \_\_\_\_\_

Second dose                      Dose \_\_\_\_\_ mg                      Time \_\_\_\_\_

Third dose                      Dose \_\_\_\_\_ mg                      Time \_\_\_\_\_

Length of time medication will be required: School Year \_\_\_\_\_ Other \_\_\_\_\_

For what purpose has medication been prescribed \_\_\_\_\_

Is the before school dose given at home \_\_\_\_\_ or school \_\_\_\_\_.

Additional instructions: \_\_\_\_\_

To comply with the Iowa Administrative Code Section 41.12 (11) entitled "Medication Administration", a physician's description of anticipated reactions of the student to the medication must be filed at the school. Please list any anticipated reactions: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Physician)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

**This completed sheet must be at your child's school before any medication will be given.**

OVER-THE-COUNTER MEDICATION PERMISSION FORM

Grades PreK-6

The following over-the-counter medications will be available to students in grades PreK-6 with prior written approval from the parent/guardian. Signature on the bottom of this form is my yearly authorization to give my child these medications. Written approval from parent/guardian must be provided annually.

Please check the medication(s) your son/daughter may receive for minor health problems. These medication(s) will be given following the District's written protocol. No medication will be administered without prior verbal consent of the parent/guardian to discuss dosing, allergies, or other underlying health concerns.

School year: 20 - 20

School building: \_\_\_\_\_

Student's name: \_\_\_\_\_ Grade: \_\_\_\_\_

I give permission for \_\_\_\_\_ to receive the  
(student name)

medication(s) checked below, according to the protocols of the school nurse.

Generic forms of the medications may be used.

- Acetaminophen (e.g. Tylenol)
- Ibuprofen (e.g. Advil, Motrin)
- Lozenges (Cough drops)
- Hydrocortisone cream (Itch-relief)

Please list all known allergies (medication or other): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date