BETHEL LOCAL SCHOOLS MEDICATION POLICY

In compliance with Ohio State Law, school personnel cannot administer any medication, **INCLUDING OVER THE COUNTER MEDICATIONS,** to students unless a medication permission form is on file in the clinic. If the medication is an over the counter medication a form must be filled out by the parent. A doctor's signature is not necessary. For prescription medications, forms must be filled out by the parent and the preScriber. These forms can be requested from the clinic by contacting the clinic aide or any of the secretaries.

Medication must be kept locked in the clinic and dispensed by the clinic aide. Students may not carry and/or self-administer without supervision, any medications, **including over the counter medications.** Ohio law makes an exception to the rule for epipens and inhalers.* Over the counter medications should be in the original package and labeled with the student's name. Prescription medications must be in the container in which the pharmacy dispensed it, with the prescription label giving the student's name, name of the medication, dosage, time and route of administration.

*Epipens and inhalers: If the parent and physician feel that the student needs to carry either of these, permission to do so is granted if the parent and physician fill out and sign the required forms. If the student has permission to carry an epipen, a back-up epipen must be provided to the principal or clinic aide.

The school is not responsible for adverse effect of medication administered at the request of the parent/guardian or for doses inadvertetly omitted.

Parents may come to the school to administer medication to their child at any time.

PLEASE RETAIN THIS POLICY FOR FUTURE REFERENCE

RETURNED THE COMPLETED MEDICATION REQUEST TO THE OFFICE.

MEDICATION/TREATMENT AUTHORIZATION FORM

STUDENT'S NAME:_____DOB**:**_____Grade/Teacher**:**_____

Best number(s) to reach during school hours:_____

Best backup person _____Emergency Phone**:**_____

Hospital of choice in case of an emergency _____

OVER THE COUNTER MEDICATION (OTC): *To be completed by the student's parent/guardian:*

These OTC Medications may be administered as directed to my child as needed:

□ Cough drops □ Tylenol (acetaminophen) □ Motrin (ibuprofen) □ Hydrocortisone cream

□ Pepto tabs □ TUMS □ Benadryl topically/orally □ Antibiotic ointment

* *If your child uses or will be using OTC medications regularly, please bring an unopened bottle to keep in the clinic.*

Other important history or tips that work for your child's typical complaints: _____

_____

_____

PRESCRIPTION MEDICINE: *To be completed by the student's parent & physician or advanced practice RN*:

Medication Name:_____ Start Date**:**_____Discontinuation Date**:**_____

Dosage:_____ Frequency**:**_____ Purpose**:**_____

Time medication is to be administered or under what circumstances**:** _____

_____

Expected side effects, if any**:**_____

Other medications student is receiving**:**_____

_____ _____ _____

Physician/APN's printed name **Signature** **Date**

Office Address**:**_____

Office Phone**:**_____Fax**:** _____Emergency phone**:**_____

** Please use a new Medication/Treatment Authorization form for each *prescription* medication.

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Parents/Guardians: *By signing below, I hereby authorize the School District and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims.*

_____ _____ _____

Parent/Guardian printed name **Parent/Guardian signature** **Date**