MEDINAH ELEMENTARY SCHOOL DISTRICT NO. 11

ADMINISTRATIVE OFFICES

700 East Granville Avenue ■ Roselle, Illinois 60172
(630) 893-3737 Fax (630) 893-4947

PRIMARY SCHOOL
22W300 SUNNYSIDE, MEDINAH, IL 60157
(630) 529-9788

INTERMEDIATE SCHOOL
7N330 MEDINAH ROAD, MEDINAH, IL 60157
(630) 529-6105

MIDDLE SCHOOL
700 E. GRANVILLE, ROSELLE, IL 60172
(630) 893-3838

DISTRICT #11 PROCEDURE FOR

Administering Medicines to Students

Medication required by a student shall generally not be administered at school. Only those medications which are necessary to maintain the student in school and must be given during school hours shall be administered. This policy refers to both prescription and non-prescription drugs.

All medications, including non-prescription drugs, i.e., cough drops, cold medicine, aspirin, cough medicine, administered in the schools shall be prescribed by an Illinois licensed physician, dentist, or podiatrist. Students who are recovering from a temporary illness or students on long term medication who require medication during the school day may bring medication to school following these guidelines:

1. A written order for prescription and non-prescription medications must be obtained annually from the student's licensed prescriber. The order shall include the information recommended by the Illinois Department of Public Health and the Illinois State Board of Education.

2. Medication must be brought to the school in the original package or appropriately labeled container.
   a) Prescription drugs shall display:
      - Student Name
      - Prescription number
      - Medication name/dosage
      - Administration route and/or other direction
      - Date and refill
      - Licensed prescriber's name
      - Pharmacy name, address and phone number
      - Name or initials of pharmacist

   b) Over the counter medications (OTC) shall be brought to school and stored with the manufacturer's original label indicating the ingredients and the student's name affixed to the container.

3. A written request shall be obtained from the parent(s)/Guardian(s) requesting the medication be given during school hours. The request must include responsibility to assure that the licensed prescribed order, written request and medication are brought to the school. The request shall be made on the School Medication Authorization Form which is available in the school office.

4. Medications must be stored in a separate locked drawer or cabinet. Medications requiring refrigeration should be refrigerated in a secure area.

5. The parent(s)/guardian(s) will be responsible at the end of the treatment regimen for removing from the school any unused medication which was prescribed for their child. If the parent(s)/guardian(s) do not pick up the medication by the end of the school year, the certified school nurse will discard the medication in the presence of a witness.

A certified school nurse will develop and manage the Medinah School District's program for administration of medications to students. The program will adhere to the guidelines of the Illinois Department of Public Health and the Illinois State Board of Education.

The Building Principal shall distribute to each student's parent(s)/ guardian(s) the District's policy and policy guidelines for Administering Medicines to Students within fifteen (15) days after the beginning of each school year, or within fifteen (15) days after starting classes for a student who transfers into the District.

This policy was developed by a committee composed of staff, parents, and the Medinah District No. 11 school nurse.

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MEDINAH DISTRICT #11

SCHOOL MEDICATION AUTHORIZATON FORM *(rev.5/16)*

Student Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____ EMERGENCY CONTACT AND PHONE:_____

School:_____ Grade:_____ Teacher:_____

TO BE COMPLETED BY A MEDICAL PROFESSIONAL AUTHORIZED TO PRESCIBE MEDICATION

(physician, physician assistant, advanced practice registered nurse, dentist, orthodontist)

Name of Medication: _____ Dosage: _____

Frequency: _____ Time Given/Instructions:_____

Diagnosis requiring medication: _____

Purpose for medication: _____

Side Effects_____

Prescription date:_____ Order date: _____ Discontinuation date:_____

Other medication student is receiving:_____

(Note: For Asthma Inhaler/Epi-Pen users only)

May student self-administer asthma medication? (Please check) ( ) Yes ( ) No

May student self-administer Epi-Pen medication? (Please check) ( ) Yes ( ) No

If yes, I certify that the student has been instructed in the use and self-administration of the medication. He/she is capable of using this medication independently.

_____ _____ _____

PHYSICIAN'S NAME (PRINT) **PHYSICIAN'S SIGNATURE** **DATE**

In the event of a reaction to the medication or an emergency, I may be reached at:

_____ _____ _____

ADDRESS **PHONE- OFFICE** **PHONE- EMERGENCY**

PHYSICIAN'S OFFICE: PLEASE FAX THIS FORM TO 630-893-4947

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Medinah School District #11 and its employees and agents, in my behalf and, to administer or to attempt to administer to my child (or to allow my child to self-administer, 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 medication(s) to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against School District #11, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify School District #11, its employees and agents, either jointly or severally, from and against any and all small claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____

Parent/Guardian Signature **Date**