Nashua Board of Education Policy JLCD-R

ADMINISTERING MEDICATION TO STUDENTS

Written Authorization

In order for prescription medications to be given at the school, the following shall occur;

1. The school nurse shall ensure that a written statement from the licensed prescriber containing the following be filed in the student's health record:
    a. The student's name;
    b. The name and signature of the licensed prescriber and contact numbers;
    c. The name, route and dosage of medication.
    d. The frequency and time of medication administration or assistance;
    e. The date of the order; and
    f. A diagnosis, if not a violation of confidentiality.

2. The school nurse shall ensure that there is a completed and signed Medical Authorization and Hold Harmless Agreement Prescription Medication form from the parent and/or guardian.

3. The school nurse shall ensure the authorization or other accessible documentation contains:
    a. The parent and/or guardian's home and emergency phone number(s); and
    b. Persons to be notified in case of a medication emergency in addition to the parent or guardian and licensed prescriber.

In order for OTC medication to be given at school, the following shall occur:

1. The school nurse shall ensure that there is a completed and signed Medical Authorization and Hold Harmless Agreement OTC Medication form from the parent and/or guardian.

2. The school nurse shall ensure the authorization or other accessible documentation contains:
    a. The parent and/or guardian's home and emergency telephone number(s); and
    b. Persons to be notified in case of a medication emergency in addition to the parent or guardian and licensed prescriber.

Delivery of Medication to School

1. A parent, guardian or a parent/guardian-designated, responsible adult shall deliver all medication to be administered by school personnel to the school nurse or other responsible person designated by the school nurse as follows:
2. The prescription medication shall be in a pharmacy or manufacturer labeled container;
3. The school nurse or other responsible person receiving the prescription medication shall document the quantity of the prescription medication delivered; and
4. The medication may be delivered by other adult(s), provided that the nurse is notified in advance by the parent or guardian of the delivery and the quantity of prescription medication being delivered to school is specified.
5. All medication shall be stored in their original pharmacy or manufacturer labeled containers and in such manner as to render them safe and prevent loss of efficacy. A single dose of medication may be transferred from this container to a newly labeled container for the purposes of field trips or school-sponsored activities.

Recording Provisions

1. Each school will document in ink or electronic record utilizing a school approved program the medication taken by each student:
    a. Date and time of administration;
    b. Name of medication prescribed;
    c. Name of licensed prescriber;
    d. Signature or initials of adult present;
    e. Other comments.
2. If a student refuses to take or spills medication, or medication is lost or has run out, such shall be recorded.
3. If an error occurs, a correction will be made in accordance with standard nursing practice.
4. Each record should be kept in a designated place for a period of time consistent with the New Hampshire Department of Education's records retention schedule.

Student Health Records

Physicians written orders and the written authorization of parents or guardians should be filed with the student's cumulative health record and kept for a period of time as determined by the New Hampshire Department of Education's Records Retention Schedule. Health records concerning students who receive special education services should be retained as long as the student is in a special education program and there is District liability for the education of the student.

An appropriate summary completed at least once every school year for each medication prescribed and taken should become part of the student's health record.

The State law forbids any child for any reason to take medication without written permission of the child's parent or legal guardian. Permission forms are available in the Nurse's office and are attached to this policy.

Board Approved: 12/17/12

H-17A-R12

NASHUA SCHOOL DISTRICT
NASHUA, NEW HAMPSHIRE

MEDICATION AUTHORIZATION AND HOLD HARMLESS AGREEMENT
PRESCRIPTION MEDICATION

To the Nashua Board of Education:

We, the undersigned, are the parents (guardians) of _____, who lives with us at _____ in Nashua, New Hampshire, and attends _____ School in the Nashua School District, and is under the care of Doctor _____ whose address is _____

The Doctor has prescribed that this child be given _____ in accordance with his/her written instructions, which are attached hereto, and we desire that the School District personnel give the child assistance in the taking of this medication. The medication is to be given at the following dates and times:

☐ AM:_____ ☐ PM_____ ☐ As needed:_____

_____ through _____
mm/yyyy mm/yyyy

We ☐ have ☐ have not attached a complete list of the student's medications. (Note: list is optional.)

We hereby agree to indemnify and hold forever harmless the City of Nashua, the Nashua Board of Education, and their respective officials, agents, servants, and employees against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement or indemnity.

Please read the above carefully before signing. No child will be assisted in taking medication until this form has been signed and delivered to the school.

_____ _____
Signature of Parent or Guardian Address

_____ _____ _____
Signature of Parent or Guardian Date Telephone Number

NOTE: A WRITTEN STATEMENT MUST BE RECEIVED FROM THE LICENSED PRESCRIBER DETAILING THE METHOD OF TAKING THE MEDICATION, THE DOSAGE, AND THE TIME SCHEDULE TO BE OBSERVED. MEDICATION SHOULD BE DELIVERED TO THE SCHOOL BY THE PARENT OR GUARDIAN AND MUST BE IN AN APPROPRIATE CONTAINER THAT IS PROPERLY MARKED BY THE PHARMACY OR MANUFACTURER. THE CHILD TO WHOM THIS PERMISSION APPLIES MUST STRICTLY FOLLOW THE INDIVIDUAL CARE PLAN WITH REGARD TO SELF-MEDICATION IN SCHOOL IN ACCORDANCE WITH THE STATE OF NEW HAMPSHIRE POLICIES ON SELF-MEDICATION.

H-17B-R12

NASHUA SCHOOL DISTRICT
NASHUA, NEW HAMPSHIRE

MEDICATION AUTHORIZATION AND HOLD HARMLESS AGREEMENT
OVER-THE-COUNTER MEDICATIONS

To the Nashua Board of Education:

We the undersigned, are the parents (guardians) of _____, who lives with us at

_____in Nashua, New Hampshire, and who attends

_____ School in the Nashua School District.

We feel that our child may benefit from the following over-the-counter medications (**not to include herbal preparations or dietary supplements)** and wish to have an appropriate person assist our child in taking the medication furnished by us in accordance with the printed instructions on the manufacturer's labeled bottle we have provided. We understand that if a higher dose than what the manufacturer recommends is needed, that a doctor's note, so authorizing the increased dosing will be provided by our child's medical provider or pediatrician.

	Needed for	
NAME OF MEDICINE, DOSE, AND INSTRUCTIONS FOR TAKING		REASON TAKING
	Needed for	
NAME OF MEDICINE, DOSE, AND INSTRUCTIONS FOR TAKING		REASON TAKING
	Needed for	
NAME OF MEDICINE, DOSE, AND INSTRUCTIONS FOR TAKING		REASON TAKING

This permission is good for one school year unless otherwise specified for a specific condition lasting <u>less than one (1) school year.</u>

We hereby agree to indemnify and hold forever harmless the City of Nashua, the Nashua Board of Education, and their respective officials, agents, servants, and employees against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance; and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement or indemnity.

Signature of Parent or Guardian	Address

Signature of Parent or Guardian	Date	Telephone Number

NOTE: PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. NO CHILD WILL BE ASSISTED IN TAKING MEDICATION UNTIL THIS FORM HAS BEEN SIGNED AND DELIVERED TO THE SCHOOL WITH THE MEDICATION IN A PROPERLY LABELED BOTTLE FROM THE MANUFACTURER. MEDICATION SHOULD BE DELIVERED TO THE SCHOOL BY THE PARENT OR GUARDIAN AND SHOULD HAVE THE CHILD'S NAME MARKED ON THE CONTAINER.

NASHUA SCHOOL DISTRICT
NASHUA, NEW HAMPSHIRE

ALLERGY MEDICATION AUTHORIZING AND HOLD HARMLESS AGREEMENT

Medication Authorizing and Hold Harmless Agreement
<u>Over-the-Counter</u> Medication

To the Nashua Board of Education:

We the undersigned, are the parents (guardians) of _____, who lives with us at

_____in Nashua, New Hampshire, and who attends

_____ School in the Nashua School District.

We feel that our child may benefit from the following over-the-counter medication:_____

Medication Authorizing and Hold Harmless Agreement
<u>Prescription</u> Medication

To the Nashua Board of Education:

We the undersigned, are the parents (guardians) of _____, enrolled in the Nashua School District who lives with us at _____ in Nashua, New Hampshire. This child is a student at _____School and is under the care of Doctor _____whose address is _____.

The Doctor has prescribed that this child be given _____ in accordance with his/her written instructions, which are attached hereto, and we desire that the Nashua School District personnel give the child assistance in the taking of this medication. The medication is to be given at the following dates and times:

<u>Dates</u>			<u>Times</u>
_____	through	_____	_____
mm/yyyy		mm/yyyy	as needed

We hereby agree to indemnify and hold forever harmless the City of Nashua, the Nashua Board of Education, and their respective officials, agents, servants, and employees against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance; and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement or indemnity.

_____	_____	_____
Signature of Parent or Guardian	Date	Telephone Number

NOTE: A WRITTEN STATEMENT MUST BE RECEIVED FROM THE LICENSED PRESCRIBER DETAILING THE METHOD OF TAKING THE MEDICATION, THE DOSAGE, AND THE TIME SCHEDULE TO BE OBSERVED. MEDICATION SHOULD BE DELIVERED TO THE SCHOOL BY THE PARENT/GUARDIAN AND MUST BE IN AN APPROPRIATE CONTAINER THAT IS PROPERLY MARKED BY THE PHARMACY OR MANUFACTURER. THE CHILD TO WHOM THIS PERMISSION APPLIES MUST STRICTLY FOLLOW THE INDIVIDUAL CARE PLAN WITH REGARD TO SELF MEDICATION IN SCHOOL IN ACCORDANCE WITH THE STATE OF NEW HAMPSHIRE POLICIES ON SELF MEDICATION.

H17C-R12

Nashua School District

Allergy Medication Instruction

Place Child's Photograph Here

Student Name _____ DOB _____

School _____ Teacher _____

Allergy _____ Asthmatic: ☐ YES (Higher risk for severe reaction) ☐ NO

STEP 1 - TREATMENT			
Reaction Area	**Symptoms**	**Administer Checked Medication** *(Determined by physician authorizing treatment)*	
Food allergen ingested	*No symptoms*	☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other*		☐ Epinephrine	☐ Antihistamine
Several Areas Above Affected	Reaction progressing	☐ Epinephrine	☐ Antihistamine

*Potentially life-threatening. ***The severity of symptoms can quickly change.***

DOSAGE						
Epinephrine:	☐ EpiPen®	☐ EpiPen® Jr.	☐ Twinject™ 0.3 mg	☐ Twinject™ 0.15 mg	*Route:*	Inject intramuscularly
Antihistamine:	*Medication:*		*Dosage:*		*Route:*	
Other:	*Medication:*		*Dosage:*		*Route:*	

STEP 2 - EMERGENCY CALLS					
1	**Call 911**	(or Rescue Squad)	Telephone:		State that an allergic reaction has been treated and additional epinephrine may be needed.
2	**Call Dr.**		Telephone:		
3	**Call Emergency Contacts:**				

	Name	***Relationship***	***Telephone 1***	***Telephone 2***
	a)			
	b)			
	c)			

AUTHORIZATION		
Parent/Guardian Signature	**Print Name**	**Date**
Doctor's Signature ***(Required)***	**Print Name**	**Date**

H-110-R12