



# Sturgis Charter Public School

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sturgischarterschool.org

## MEDICATION CONSENT FORM & POLICY

August 2009

Dear Parent/Guardian,

**PLEASE NOTE THAT THE POLICY REGARDING ANY MEDICATION USE AT THE SCHOOL HAS CHANGED AND WILL BEGIN EFFECTIVE 2008-2009**

The medication policy has been put in place to provide a safe, consistent and reasonable approach to the taking of medication by children during school hours. Generally, medications should be given at home. When it is necessary that medication be taken at school, the following protocol will be followed:

1. Signed Parent/Guardian Consent for SPECIFIC non-prescription medication (Ibuprofen/cough drops/antacid tablets/Acetaminophen)  
**STUDENTS MAY RECEIVE (7) DOSES OF SPECIFIC MEDICINE WITHIN A SCHOOL YEAR. AFTER THE SEVENTH DOSE, THE PARENT AND PHYSICIAN MUST BE NOTIFIED. FURTHER ADMINISTRATION OF THE MEDICINE REQUIRES LICENSED PROVIDER ORDER.**
2. Prescription medication(s) or expected greater use of the above listed non-prescription medications requires a signed parental prescription administration form and a medication order form completed by a licensed provider.

Prescription medicine must be delivered by the parent/guardian. Another adult may be designated, provided arrangements are made with the nurse in advance. The medicine must be in the prescription bottle or manufacturer labeled container. Please ask the pharmacist for a second bottle for school field trips. No more than a 30 day supply should be delivered to the school.

All medications must be administered by the school nurse unless arrangements have been made for self administration.

**THE SCHOOL NURSE WILL DETERMINE THE SAFETY OF SELF ADMINISTRATION AND BOTH THE LICENCED PROVIDER AND PARENT/GUARDIAN MUST CONSENT AS WELL.**

### ATTACHMENTS:

1. PRESCRIPTION MED CONSENT FORM
2. MEDICATION ORDER
3. NON-PRESCRIPTION MED CONSENT FORM

Sincerely,

Patricia O'Toole, RN, BS School Nurse



# Sturgis Charter Public School

## MEDICATION CONSENT FORM & POLICY

### SPECIFIC NON-PRESCRIPTION MEDICATION ADMINISTRATION PARENT/GUARDIAN CONSENT FOR

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Food/Drug Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

Health Concerns/Diagnoses \_\_\_\_\_

The school nurse may assess and administer the following over-the-counter medications to my child during the school year.

- **Acetaminophen** (Tylenol 325 mg) 1-2 tablets as needed for minorin, headache, etc.
- **Ibuprofen** (Advil/Motrin 200mg) 1-2 tablets every 4 hours as needed for minor pain, headache, muscle strain, menstrual cramps, etc.
- **Cough drops** (generic brand) 1-2 as needed for minor throat discomfort or cough
- **Antacid tablets** (Calcium carbonate 600mg) 2-4 tablets for relief of indigestion followed by a 1/2 glass of water

**I give permission to the School Nurse to share information relevant to the administered medication as she/he determines appropriate for my son's/daughter's health and safety.**

I GIVE CONSENT FOR MEDICATION ADMINISTRATION: \_\_\_\_\_ Yes \_\_\_\_\_ No

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent comments/instructions: \_\_\_\_\_

School Policy now requires a physician order for more than occasional use of analgesics (acetaminophen & ibuprofen) by the student during the school year. The school nurse will notify the parent/guardian if their child requires an additional order from their primary care physician (PCP). In addition, the school nurse will forward this form to the PCP for signature should the need arise or the school nurse may determine that the more detailed consent and order form will need to be used. If excessive use of cough drops or antacids occurs the nurse will contact home and recommend a medical evaluation.

**I give the nurse permission to forward this form to my child's PCP in the event my Son/daughter requires more than occasional use of analgesics as outlined in the school policy.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

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**PHYSICIAN ONLY**

Physician signature: \_\_\_\_\_ Date \_\_\_\_\_

Additional orders: \_\_\_\_\_



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### PRESCRIPTION MEDICATION ADMINISTRATION

Student's name \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_

Telephone number Home: \_\_\_\_\_ Cell Phone number \_\_\_\_\_

Telephone number Work: \_\_\_\_\_ Emergency: \_\_\_\_\_

Other person(s) to be notified in case of medication emergency:

Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Cell number: \_\_\_\_\_

My son/daughter has the following food or drug allergies: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Route of Administration: \_\_\_\_\_ Time(s) of Administration \_\_\_\_\_

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

\_\_\_\_\_ to: \_\_\_\_\_

Licensed Prescriber

Student's name

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

\_\_\_\_\_ Yes \_\_\_\_\_ No

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I give permission to the School Nurse to delegate medication administration to my child's teacher/ designee for field trips.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or before the close of school.

Parent/guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## MEDICATION CONSENT FORM & POLICY

### MEDICATION ORDER

(To be completed by a Licensed Provider: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Emergency phone number \_\_\_\_\_

Medication \_\_\_\_\_

Route of Administration \_\_\_\_\_ Dosage \_\_\_\_\_

Frequency \_\_\_\_\_ Time(s) of Administration \_\_\_\_\_

**Please note: Whenever possible, medication should be scheduled at times other than school hours**

Specific directions or information for administration \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Diagnosis \* \_\_\_\_\_

Any other medical condition(s) \* \_\_\_\_\_

### Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed

\_\_\_\_\_  
\_\_\_\_\_

2. Other medications being taken by the student \_\_\_\_\_

3. The date of the next scheduled visit or when advised to return to the prescriber \_\_\_\_\_

\_\_\_\_\_

4. Consent for self administration ( provided the school nurse determines it is safe and appropriate

\_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Signature of Licensed Prescriber

\_\_\_\_\_  
Date

*\* if not in violation of confidentiality*