EDGEWOOD HIGH SCHOOL OF THE SACRED HEART

SCHOOL MEDICATION ADMINISTRATION (SMA) FORM

*This form is to be used for all medication. A new form must be completed every school year.*

Date_____

Student Name _____ Date of Birth _____

School _____ Grade _____

**Physician's Authorization for Prescription and Non-Prescription Medication**

*To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority.*

Medication_____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Dose/Frequency_____Route _____Time_____ ☐Scheduled ☐PRN

Effective dates (limited to 1 school year) From: _____To: _____

Intended effect _____ Possible side effects_____

Special Instructions _____Condition(s) requiring medication_____

Other medication(s) student is taking _____

**Physician's Signature**_____**Date** _____

**Physician's Printed Name** _____**Phone** _____

**Address** _____**Emergency Phone** _____**Fax** _____

**For Asthma Medication and/or Epinephrine Injector Only**

*To be completed by physician:*

Is self-carry of asthma medication authorized? □ Yes □ No Is unsupervised administration of asthma medication authorized? □ Yes □ No

Is self-carry of epinephrine injector authorized? □ Yes □ No Is unsupervised administration of epinephrine injector authorized? □ Yes □ No

I or a member of my staff have instructed the above student in the proper self-carry and self-administration, if authorized, of the above-identified medication(s). The student understands the need for the medication, the appropriate response, and the necessity to report to school personnel any unusual side effects or lack of appropriate response. The student is capable of using this medication independently.

**Physician's Signature**_____ **Date** _____

**Physician's Name** _____**Phone** _____**Fax** _____

*****Parent's Authorization must be completed and signed on page 2.*****

| **For School Use: PRN Medication Administration** | | | | | | | | | Medication Intake:____/____/____ Amount:_____ | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | | | | | | |
| Time | | | | | | | | | | | | | |
| Initial | | | | | | | | | | | | | |
| Date | | | | | | | | | | | | | |
| Time | | | | | | | | | | | | | |
| Initial | | | | | | | | | | | | | |

Signature_____Initial_____ Signature_____Initial_____ Signature_____Initial_____

**Parent/Guardian Authorization**

I hereby acknowledge 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 Edgewood High School of the Sacred Heart and its employees and agents, on my behalf and stead, to administer or attempt to administer, or allow my child to self-administer, the lawfully prescribed medication in the manner described in this authorization form.

I further understand that my child may be administered an undesignated epinephrine injector, opioid antagonists, or asthma medication when school personnel have a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available onsite or has expired.

I acknowledge that it may be necessary for the administration of medication(s) to my child to be performed by an individual other than the school nurse, and specifically consent to such practices.

I waive any claims I might have against Edgewood High school, the Board of Education and its members, its employees, and its agents arising out of the administration or my child's self-administration of said medication(s). In addition, I agree to hold harmless and indemnify the School District, the Board of Education and its members, its employees, and its agents, either jointly or severally, from any and all claims, demands, damages, and causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the negligent administration of self-administration of medication(s).

**For Asthma Medication and/or Epinephrine Injector ONLY**

*To be completed by parent/guardian of students who need to self administer medication asthma inhalers and/or epinephrine injector. Please initial.*

Is the asthma medication an/or epinephrine injector required under a qualifying plan, such as: (1) an asthma action plan, (2) an Individual Health Care action plan, (3) a Food Allergy & Anaphylaxis Emergency (FARE) action plan and treatment authorization form, (4) a plan pursuant to Section 504 *Rehabilitation ACt of 1973,*or (5) a plan pursuant to the federal *Americans with Disabilities Act*? □ Yes □ No

I consent only to my child's self-carry of asthma medication: _____
I consent to my child's self-carry and unsupervised self-administration of asthma medication: _____

I consent only to my child's self-carry of an epinephrine injector: _____
I consent to my child's self-carry and unsupervised self-administration of an epinephrine injector: _____

**For Self-Administration of Medication other than Asthma Medication and/or Epinephrine Injector ONLY**

*To be completed by parent/guardian of students who need to self administer medication (other than asthma inhaler and/or epinephrine injector) required under a qualifying plan. Please initial.*

I consent to my child's self-administration of his/her medication (other than an asthma inhaler and/or epinephrine injector) required under an asthma action plan, diabetes action plan, Chrone's/irritable bowel syndrome (IBS) plan, migraine action plan, seizure disorder or a plan pursuant to the federal *Americans with Disabilities Act*.

**Parent/Guardian Signature_____Phone Number_____Date _____**

SCHOOL MEDICATION AUTHORIZATION AND ADMINISTRATION PROCEDURE

Whenever possible, the parent/guardian should make arrangements for medication to be administered at home, before or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, **school policy and procedures must be followed for administering all medications, as outlined in in the Edgewood Student Handbook.**

- Medication is defined as prescription or non-prescription (over the counter) drugs.
- Medication cannot be administered without a written physician's order and written parent/guardian permission.
- Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must be brought in with the original manufacturer's label, clearly marked with the student's name.
    - For asthma inhalers, attach the prescription label with the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.
    - For epinephrine injector, attach a written statement from the student's physician, physician assistant, or advanced practice registered nurse containing the anime and purpose of the epinephrine injector, the prescribed dosage, and the time(s) at which or the special circumstances that the epinephrine injector should be administered.
- It is the parent/guardian responsibility to supply prescribed medication and assure that it is brought to school by a responsible person.
- All medications to be taken during school hours will be kept in the nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication.
- In the absence of the school nurse, a trained delegate will be available for medication administration.
- The parent/guardian must assume responsibility for informing the school (in writing) of any change in the student's health or change in medication. Physician's order must accompany any medication change.
- The school retains the discretion to reject requests for administration of medication if all required information is not received on the authorization form.