Coeur d'Alene School District No. 271 **3510F3**

SCHOOL MEDICATION AUTHORIZATION FORM School Year _____ - _____

Student Name: _____ Birthdate: _____

Physician: _____ Fax: _____

School: _____ Grade: _____

DO NOT use this form for students needing insulin or emergency medications for asthma, severe allergy/anaphylaxis, or seizure disorder at school. School diabetes orders, or an asthma, life threatening allergy, or seizure disorder medication order is required. Forms are available from the school office or district website: www.cdaschools.org (Departments tab/Health Services/ School Health Forms)

THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL (LHP) WITH PRESCRIPTIVE AUTHORITY

Name of Medication*	Dosage	Method of administration	Time(s) of day to be given

***One medication per request form**

Reason for medication: _____
For as needed medications, specify the minimum length of time between doses: _____
Possible side effects and action needed if noted at school: _____

For short term inhaler treatment for respiratory infection: In my office, this student has demonstrated the ability to correctly self-administer this medication (inhaler or other device) and may carry the medication on his/her person. □ Yes □ No □ N/A

I request/authorize the above named student be administered the above named medication in accordance with the instructions indicated above from _____ to _____ or the entire school year including summer months (if applicable), as there exists a valid health reason which makes administration of medication advisable during school hours. **Medication orders are valid for the current school year only.**

Date of Signature: _____ LHP Signature: _____

Phone: _____ Fax: _____ LHP's Name (print): _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Please read Parent Information on the reverse side of this form.

I have read and understand the parent information regarding medication at school (reverse side or school office) and request/authorize trained school staff to administer medication to my child in accordance with the LHP's instructions above for the dates of _____ to _____ or one entire school year including summer months (if applicable). Medication orders are valid for the current school year only.

I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule. I also give my permission for the exchange of information between school district nurse and LHP for the purpose of clarifying medication orders/concerns that could affect safe administration at school.

Please complete the following, IF the above medication is an inhaler device that will be used for a short period of time:

For short term inhaler treatment for respiratory infection:

My child will carry inhaler on his/her person and is trained and capable to self-administer. ❑ Yes ❑ No ❑ N/A

If so, I will provide a second "back up" inhaler for school. ❑ Yes ❑ No

Note: If your child requires medication for asthma or anaphylaxis for an extended period of time, contact the school nurse. An Asthma or Severe Allergy Care Plan which includes medication orders is required.

The District shall incur no liability as a result of any injury arising from the self-administration of medication.

Date of Signature: _____ Parent/Guardian Signature _____

Home Phone: _____ Work/Cell Phone: _____ Alternate Phone: _____

This record must be maintained by the school district for 5 years.

Form (3510F3) Rev. (5/23)

Coeur d'Alene School District No. 271 **3510F3**

PARENT INFORMATION: MEDICATIONS AT SCHOOL

Dear Parent/Guardian,

Your child's safety and the safety of others is our primary concern when medication is needed during school hours. Whenever possible, medications should be administered at home, outside of school hours.

The following requirements must be met if trained school personnel administer medication to your child during the school day (see District Policy 3510):

1. **Medications are administered by unlicensed school staff.**
   - Licensed registered school nurses delegate medication administration to specific unlicensed assistive personnel (UAP).
   - Medications that must be calculated or mixed cannot be administered by unlicensed school staff, except in an emergency per I.C. § 54-1412.
   - Contact your school nurse if assistance with medications or other types of treatments are needed.
2. **Medication must be delivered to school by the student's parent/guardian or other responsible adult.**
   - Please allow time for school staff to count pills/capsules with you.
3. A **medication authorization form must be completed** before any medication can be given by school staff. This form is available from the school office or at: www.cdaschools.org (Departments tab/Health Services/ School Health Forms)
   - The form must be completed and signed by the student's LHP.
   - The form must be completed and signed by the student's parent/guardian.
   - A form must be submitted for each medication, including over-the-counter medications such as pain relievers, cough drops, cold medicines, and prescription medications.
   - The completed medication authorization form can be hand delivered, mailed or faxed to school.
4. All **medication must be in a properly labeled container.**
   - Prescription medication must be in a container labeled by a pharmacist or physician with the correct name of medication, dosage, and time for school administration.
   - Over-the-counter medication must be in its original container, labeled with your child's name.

Self-carry/administration requirements:

For the safety of all students, we prefer that all medications are stored securely and administered by trained staff. However, at times, parent/guardian may thoughtfully decide that their child needs to carry their medication at school. To self-carry medication, the student must be able to self-administer without any assistance or reminders.

The following requirements must be met if medication is to be carried by a student:

1. Only five day's doses may be carried unless as in the case of, inhalers, such a request is impossible.
2. Student must have a Self-Administration Authorization Form signed by their parent/guardian in their possession, authorizing them to self-carry.
3. The form must contain:
   - Date(s) the student will be carrying medication
   - The name of the medication
   - Parent signature and parent contact information
   - LHP name and contact information
   - One note can be used to cover an entire week/ month/year for medication use "as needed"
   - An acknowledgment that the district will not incur any liability as a result of any injury arising from the self-administration of such medication, a waiver of any such liability, and an indemnity and hold harmless agreement.

Note: There are different requirements for students that self-carry/administer for asthma, life-threatening allergy or diabetes. See information at the top of the Medication Authorization Form.

Other considerations:

- The building principal/designee has the right to further restrict medications that are self-carried.
- **Students that are not using their medication responsibly may lose their right to carry medication and be subject to disciplinary proceedings.**
- An electronic medication record will be maintained for all students for which medication is administered by school staff.
- Medications not retrieved by the parent/guardian when discontinued or at the end of the school year, will be destroyed.
- Students with diabetes, asthma and life-threatening allergy are guaranteed the right to carry insulin and all supplies necessary for treatment, monitoring and emergency situations for example emergency snacks, glucose tablets, water bottles, rescue inhaler/metered dose inhaler or epinephrine auto-injector.

Thank you for your cooperation and assistance in maintaining a safe school environment.
Please contact the school nurse for questions or concerns.