MEDICATION IN THE SCHOOL

HORIZON SCIENCE ACADEMY-Springfield

Ohio law requires schools to adopt policy and develop procedures regarding the administration of prescribed medications to student if he school permits such administration. Every effort should be made to have required medications given to the student before or after school hours.

Administration Requirements

A. No medication that is prescribed by a physician for a student shall be administered to that student unless:

1. The school administrator receives a **written request by the parent/guardian** that the drug may be administered to the student.

2. The school administrator shall receive a **written statement signed by the physician** who prescribed the medication that includes the following information:

    A. The name and phone number of the student;

    B. The name of the medication and the dosages to be administered.

    C. The times at which the medication is to be administered.

    D. The dates the administration of the medications is to begin and cease.

    E. Any severe, adverse reactions that should be reported to the physician and one or more phone numbers at which the physician can be reached in case of an emergency.

    F. Any special instructions for the administration of the drug, including storage.

3. The Parent/Guardian agrees to:

    A. Bring the medication to school in a container from the pharmacist properly labeled including the name of the student, physician, date, dosage, instructions (quantity and time) and name of medication. The school will accept medications in pill/unit dose form. The school will not be responsible for administering injections; liquid medications, including ear drops and eye drops; applying ointments; changing dressings or spitting pills

    B. Submit a separate medication request form for each medication.

    C. Submit a new medication request form with parent and physician signatures if the previously provided information changes. A new pharmacy label is also needed. A new request form is to be provided every year.

    D. Pick up any remaining medication when discontinued or at the end of year. Any medication that has not been picked up by parent or guardian will ne discarded.

    E. Release Horizon Science Academy, and the assisting employees of the Horizon Science Academy from liability arising from the assistance in the administration of this medication.

B. The Horizon Science Academy may adopt any other required procedures that must be followed in the administration of this medication.

C. **This policy is enforced for "all over the counter" medications, including but not limited to Tylenol, cough syrups, cold tablets, pain pills, etc.**

We appreciate your continual support!

Request for Administration Medication During the School Day _______ Year

A New Form Must Be Completed Each Year

Student Name: ______________________ **D.O.B.** __________ **Grade:** ______

Phone: ______________________ **Email:** ______________________

Part 1: TO BE COMPLETED BY PHYSICIAN/MEDICATION TO BE TAKEN

Medication: ______________ **Dosage:** ____________ **Dosage Time/Intervals:** ____________

Administration to Begin: ______________ **Administration to End:** ______________

Severe Adverse Reaction to be Reported to the Physician:

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Special Instructions for Administration of Medication and/or Sterile Conditions or Storage:

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The School will accept medications in pill/unit dose form. The school will not assume the responsibility for administering injections; liquid medications, including eardrops and eye drops; applying ointments; changing dressings; or splitting pills.

Name of Physician: ______________________________

Address of Physician: ______________________________

Telephone Number: ______________ **Emergency Number:** ______________

Signature of Physician: ______________________________

Part II: TO BE COMPLETED BY PARENT OR GUARDIAN

I request that the above described medication to be administered to my son/daughter according to the instructions provided under the supervision of a member of the adult school staff; and I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. If the above information changes, I will submit a new request form signed by the physician.

I have read the additional policies regarding administration of medication and understand the condition under which the medication will be administered. I understand that the school personnel are not legally obligated to administer oral medication to an child and therefore, I agree to hold Horizon Science Academy and its employees free from any and all responsibility for the results of such medication or the manner in which it s administered and to indemnify each of them against loss by reason of any civil judgments arising out of these arrangements which may be rendered against them. I Also authorize the exchange of information between the physician and the school regarding the health care needs of my son/daughter when deemed necessary by school personnel. I understand it is my son/daughter's responsibility to request medication at the proper time.

Signature of Parent/Guardian: ______________________________ Date: __________

Address: ______________________________

Home Phone: ______________________ Work Phone: ______________________

PART III: TO BE COMPLETED BY THE SCHOOL

Date Received : ______________ Accepted: __________ Denied: __________

Reason for Denial: ______________________________

The following school personnel have read this form and are authorized to assist in the administration of the medication outlined above:

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________