ALABASTER CITY SCHOOLS MEDICATION PRECEDURES SUMMARY

Dear Parents/Guardians,

Each year, Alabaster City Schools approves **medication procedures** for all students in our school system. This summary is to inform you of the requirements of the medication procedures, should your child require **Prescription or Over the Counter (OTC)** medications while attending school.

- **All medications**, whether Prescription or Over-the Counter (OTC) ***must*** **be turned into the school office by the student's parent/guardian** or other responsible adult.
- **Medications *cannot* be transported on the bus** *(except emergency medications and approved medications prescribed for self-administration.)*
- No student will be permitted to carry or possess any type of medications, whether Prescription or Over-the Counter, on his/her person at any time (*except emergency medications prescribed for self-administration.)*
- **Controlled substances cannot** be approved for self-administration by a licensed prescriber.
- **The parent/guardian must sign a School Medication Physician/Prescriber/Parent Authorization Form (Attachment #1)** before **any** medication, Prescription or Over-the Counter, can be administered at school.
- Over-the Counter medications will require the **parent/guardian signature *only*** on the medication authorization form and is valid for the entire school year.
- Prescription medication **will require the physician/prescriber signature on the authorization form (Attachment #1) as well as the parent/guardian signature.**
- Prescription **samples** must have a completed School Medication Physician/Prescriber/Parent Authorization Form signed by the **Prescriber and Parent.**
- If the Prescription medication order is **changed** during the school year, a **new** authorization form (Attachment #1) is required. Both physician/prescriber and parent/guardian must sign the form.
- For **Prescription** medications, a **current pharmacy labeled** container is required which includes the student's name, physician name, name of medication, strength, dosage, time interval, route, and date of drug's discontinuation when appropriate.
- For **Over-the-Counter** medications, **an unexpired, unopened, age appropriate,** original container is required and all manufacturers' labeling must be clearly legible. The student's name must be written on the container.
- The school will not supply any Prescription or OTC medications to staff or students.
- All unused medications not picked up by parents/guardians by the **last day of each school year will be discarded** according to medication procedure guidelines.
- It is the parent's responsibility to make the school nurse aware of any medical services needed for after school activities.
- Non-FDA approved supplements/substance used to treat medical conditions, including essential oils and CBD type oils can NOT be administered at school. Students, parents, and staff are not allowed to possess CBD oil substances on school property.

These medication procedures were adopted with your child's safety in mind. If you have any questions concerning these medication procedures, please contact your school nurse.

ATTACHMENT #1

ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

School Year:_____-_____

Student's Name: _____ **School:** _____

Date of Birth:____/____/____ Age: _____ Grade:_____ Teacher: _____

□ **No known drug allergies---if drug allergies list:**_____ Weight:_____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name:_____ **Dosage:**_____ **Route:** _____

Frequency/Time(s) to be given:_____ **Start Date:**___/___/___ **Stop Date:**___/___/___

Reason for taking medication: _____
Potential side effects/contraindications/adverse reactions: _____
Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ϒ No ϒ
Is self- medication permitted and recommended? Yes ϒ No ϒ
If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.
Do you recommend this medication be kept "on person" by student? Yes ϒ No ϒ

Printed Name of Licensed Healthcare Provider:_____ **Phone: ( )**_____-_____ **Fax:**_____-_____

Signature of Licensed Healthcare Provider:_____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature:_____ **Date:**___/___/___ **Phone: ( )**_____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent:_____ **Date:**____/____/____ **Phone: ( )**_____-_____