MEDICATION FORM

Name:_____ **D.O.B:**_____

Do NOT use this form for epinephrine auto-injectors or asthma inhalers/medication. For those, please use the Food Allergy and/or Asthma Action Plan forms.

TO BE COMPLETED BY THE LICENSED PRESCRIBER (MD, APN, OR PA-C):

Medication/Dose/Frequency:_____
Duration (length of time to be given):_____
Indication of medication (diagnosis/symptom):_____

Medication/Dose/Frequency:_____
Duration (length of time to be given):_____
Indication of medication (diagnosis/symptom):_____

Medication/Dose/Frequency:_____
Duration (length of time to be given):_____
Indication of medication (diagnosis/symptom):_____

Medication/Dose/Frequency:_____
Duration (length of time to be given):_____
Indication of medication (diagnosis/symptom):_____

Prescriber (print name):_____

(use for original Prescriber stamp or fill out below)

Phone #:_____
Fax #:_____
Date:_____
Signature:_____

1531 Jones Point Road
Grayslake, IL 60030
(847)543-9722
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Prairie Crossing Charter School Procedure for Administration of Medication to Students

This procedure shall apply both to prescription and nonprescription medication. Medication shall not be administered to a student unless absolutely necessary to maintain the attendance of the student. If it is determined that the student must be given medication, the procedure set below shall be followed:

1) Medication shall be administered by a certified school nurse, registered nurse, or certified employee designated by the Director.
2) The student's physician shall provide written orders with the name of student, date of birth, name of medication, dose/route/frequency, as well as diagnosis for which medication ordered, intended effects and side effects of medication. List any other medication that the student is on and an emergency number where the physician/practitioner can be reached.
3) The student's parent/guardian shall provide to the nurse a signed authorization to administer the medication, which has been ordered by the physician/licensed practitioner. The authorization shall include the parent/guardian signature and phone number to be reached in the case of an emergency.
4) Medication brought to school shall be given to nurse/certified employee in original package or appropriately labeled container. For prescription medication, the student's name, medication name and dosage, administration directions, date and refill, licensed prescriber's name, pharmacy name, number, address, and name or initials of pharmacist. Over the counter medication to be in the original box with manufacturer's label listing all contents. Student's name must be on container. Medication should be delivered to school by parent/guardian.
5) Medication will be kept in a locked cabinet.
6) The school nurse will keep a written record of all medications administered. This record will include the student's name, medication, dose, time, date and who administered medication. In the event a dosage is not administered as ordered, the reason will be entered in the record. This documentation, along with the physician's order and parental/guardian authorization is considered part of the student's temporary record.
7) The student's parent/guardian will be responsible for removing any unused medication from the school at the end of the prescribed regimen, or end of school year. If the parent/guardian fails to remove unused medication, the school nurse will appropriately dispose of in the presence of a witness.

No medication will be administered to students unless these guidelines are followed. A student with asthma inhalers, epinephrine auto-injectors, and insulin may self-administered as long as the following information is kept on file in the Health Office. The student's parent/guardian will provide a parental written authorization for self-administration of medication and written order from the student's physician containing the following information: name and purpose of medication, prescribed dosage and time or special circumstances under which the medication is administered.

The Director or designee shall have the discretion to reject requests for administration subject to the requirements of Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act of 1973.

TO BE COMPLETED BY PARENT:
I hereby request and grant permission for PCCS school personnel to administer medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a registered nurse, and I specifically consent to this. I further waive any claims against the school district, members of the Board of Directors, its employees and agents, arising out of the administration of said medication (s), and agree to hold harmless and indemnify PCCS, the members of the Board, its employees and agents, either jointly or separately, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorney's fees, resulting from or arising out of the administration of the medication.

Parent/guardian signature:_____ Date:_____

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