Medication Policy

The Auburn School Department will not be responsible for the administration of non-prescription medication without a Doctor's order. The Auburn School Department requests that parents ask their physicians to schedule the administration of all medications during non-school hours if at all possible. If prescription medication must be taken during school hours, no student will be permitted to ingest that medication without the supervision of the school nurse.

The following rules will apply concerning the administration of medications in the schools.

1. Prescription medication is to be administered by the school nurse based upon information supplied by the student's parents, doctor and directions on the prescription container.

2. Emergency medication: Oxygen, Epinephrine, Benadryl, Glucose (such as those required for diabetic reactions, asthmatic attacks and bee sting allergies) must be accompanied with specific directions from a physician concerning administration. As per 1996 (current) state regulations 105 CMR 210.00 epinephrine (Epi-pens) may be administered by unlicensed personnel, trained by the school nurse (RN) when a student is diagnosed with a life threatening allergic condition and the school nurse is not immediately available.

3. In order to have prescription and/or emergency medication administered in the school the parent must submit a Medical Permission Form to the school nurse. This form must be signed by the parent and physician and completed in full by the physician.

4. At the elementary level (K-5) all medications must be brought to school by the parent or guardian.

5. All prescription medication must be kept by the school nurse in a locked cabinet or refrigerator. Prescription medications must be in the original pharmacy container with clearly written instructions for administration.

Voted by ASC.
6-5-97

AUBURN PUBLIC SCHOOLS
MEDICAL PERMISSION FORM
Prescription Drugs

When a student must take medication prescribed by a doctor during school hours, a medication permission form must be filled out by a physician and parent. The parent or guardian must bring the medication to school in the original pharmacy container (grades K-5). The information on the label must coincide with the information given on the permission slip.

To Physician:
If it is necessary for the below named student to take medication during school hours, please complete this form.

Name of Student_____ Birth Date _____

Address _____

School _____ Grade_____

Diagnosis (* If not in violation of confidentiality) _____

_____

Date Medication to begin:_____ Date Medication to be discontinued:_____

Medication Prescribed:_____

Dosage & Route _____

Time during school to be given _____

Any side effects, contraindications, or adverse reactions to be observed: _____

_____

Other Medications taken by student, if not in violation of confidentiality_____

_____

Date Return Visit to physician recommended:_____
Additional Comments: _____

_____

_____

Date _____ Physician's Signature _____

Physician's Address & Phone Number_____

To Parent or Guardian:
I, the undersigned, give permission to the school personnel to administer to my child the above medication. I understand that the school personnel are not responsible for any problems arising from the taking of this medication, its side effects (if any) or for the omission of medication. I further agree to hold harmless the Auburn School Department and its agents and servants against all claims as a result of any or all acts performed under this authority.

I give permission for my son/daughter to self administer medication if the school nurse determines it is safe and appropriate.
Yes_____ No _____
I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety.
Yes_____ No _____Any Restrictions on Release _____

Date_____ Parent or Guardian _____

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ ☐ Male ☐ Female **Date of Birth:** _____

Medical History _____

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____(____%) Wgt: _____(____%) BMI: _____(____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____
Group Practice Telephone

_____ _____ _____ _____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** ☐ female ☐ male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____