

MEDICATION POLICY

- I. The Auburn Public Schools (APS) follows the regulations under the Massachusetts Department of Public Health 105 CMR 210.000: THE ADMINISTRATION OF PRESCRIPTION MEDICATIONS IN PUBLIC AND PRIVATE SCHOOLS and the Massachusetts Department Board of Registration in Nursing of Regulations. The APS school nurses shall supervise the medication administration program in their respective schools. The APS school nurses shall develop and oversee procedures to administer such a program. Such procedures shall be revised by the APS School Physician on a bi-annual basis. Nursing staff shall establish a record-keeping program for each student requiring medication.
- II. The school nurse shall develop, with parents/guardians when possible, a medication administration plan for each student requiring such medication administration. The Department of Elementary and Secondary Education Guidelines for special education require student consent for the 18-21 age group and student participation in planning after age 14 if appropriate. Provision for medication administration during field trips and other short-term special events shall be part of the plan. Nurses will not delegate medication administration for out-of-state field trips.
- II. A student may be responsible for self-administration of his or her own medications upon meeting certain requirements established by procedures in (I).
- III. Alternative therapies such as homeopathic, herbal, and nutritional supplements will only be administered when there is a written order from a Massachusetts licensed prescriber who is caring for the student. The school nurse may not administer any type of regiment if it is not approved by the FDA, in accordance with the Nurse Practice Act and 105 CMR 210.000.
- IV. Medication errors - Failure to administer medication according to the prescribed order will be reported to the parent and the APS nurse leaders as procedure established in (I).

REFS: 244 CMR 4.00
 105 CMR 210.000
 Nurse Practice Act
 MA DESE Certification of School Nurses

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Auburn Public Schools

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 (e.g. K-S). 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 _____