## SPIRO PUBLIC SCHOOLS

## Procedure for Medication Administration

If it is necessary that a medication be given during school hours the following requirements must be met:

- Medication will not be administered in school or during school-sponsored activities without a Medication Request and Release Form being signed by legal parent or guardian.
- Prescription medication must be ordered or advised by a licensed physician/dentist, and permission is granted for exchange of verbal and/or written communication between the school staff and the prescribing physician/dentist regarding this medication.
- Prescription medication must be brought to school in the current original container with pharmacy label intact. The label must have the student's name, name of medication, dosage, and time to be given. If the medication is <u>not</u> properly labeled, it will <u>not</u> be given.
- Parents/guardians may ask the pharmacist for a separate container labeled just for the school time dose.
- Over-the-counter medications must be in an <u>unopened</u> original container. Student's name must be written on the box/bottle, the dosage and frequency to be given must be consistent with label instructions.
  - \*\*Medication cannot and will not be accepted in baggies or envelopes!
- For student's safety, it is recommended that the parent/guardian bring the medication to the school.
- The school cannot send medications home with students.
- At the end of the school year any remaining medication must be picked up by the parent/guardian or it will be destroyed.
- By signing the Medication Request and Release Form, the parent/guardian with legal custody understands that under state law the Board of Education, the Spiro Public School District, or employees of the District shall not be liable to the student or the student's parents or guardian for civil damages for any personal injuries to the student which result from acts of omissions and/or adverse effects of this medication.
- The parent/guardian agrees to provide medication and any particulars connected with administering medication at their own expense.
- The parent/guardian will promptly notify the school of any change in the administration of this medication and will provide the school with new prescription bottle and physician order. Written or verbal changes from parent/guardian cannot be accepted.
- The parent/guardian will notify the school of any physician change and obtain a new written prescription.

## SPIRO PUBLIC SCHOOLS

OVER-THE-COUNTER MEDICATION  Fill out and return to school with a New Unopened Container  Fill out and return to school with a New Unopened Container  Medication:	Student:	School:	Teac	her:	
Medication:	OVER-THE-COUNTER MEDICATIO	ON TO BE	COMPLETE	D BY THE PAR	ENT
Purpose:	Fill out and return to school with a New U	nopened Conta	iner of age ar	d dose appropria	te medication
Dates to be given:	Medication:	Do	sage:		
PRESCRIPTION MEDICATION  Spiro Public School discourages the administration of medication to students in school if possible. This form will only be valid for the current school year. A new form is required yearly.  PLEASE USE A SEPARATE FORM FOR EACH MEDICATION  Medication:  Trade Name and/or Generic  Dosage:  Time(s) to be given at School:  Method of administration; ORAL   Liquid   Tablet   Inhaler   DROPS   Eye R L   Ear R L   TOPICAL   apply where   OTHER   OTHER   Possible Side Effects:  If medication is PRN (as needed), please specify:  Signs and Symptoms  Can Medication be Repeated?   Yes   No   How Many Times?  Prequency of Administration  Physician's Name (Please Print)   Physician or Representatives Signature   Physician's Phone   Date    ** SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION   AUTHORIZATION/APPROVAL   Provisions under 70 O.S. 1984, Section 1-1163, allow students to self administer prescribed asthmatic, diabetic, or allergic medication. Approval to self administer medications must be authorized by the prescribing physician. The parent or guardian of the student is to provide the school an emergency supply of the student's medication.    I have instructed   in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.    Physician's Signature   Date	Purpose:	Time(s	) to be admini	stered:	
PRESCRIPTION MEDICATION  Spiro Public School discourages the administration of medication to students in school if possible. This form will only be valid for the current school year. A new form is required yearly.  PLEASE USE A SEPARATE FORM FOR EACH MEDICATION  Medication: Diagnosis: Trade Name and/or Generic  Dosage: Time(s) to be given at School:  Method of administration: ORAL Liquid Tablet Inhaler DROPS Eye R L Ear R L TOPICAL apply where OTHER   Method of administration: ORAL Liquid Tablet Inhaler DROPS Eye R L Ear R L TOPICAL poply where OTHER   Method of administration is PRN (as needed), please specify:  If medication is PRN (as needed), please specify:  Signs and Symptoms  Can Medication be Repeated? Yes No How Many Times?  Physician's Name (Please Print) Physician or Representatives Signature Physician's Phone Date  **SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL  Provisions under 70 O.S. 1984, Section 1-1163, allow students to self administer prescribed asthmatic, diabetic, or allergic medication. Approval to self administer medications must be authorized by the prescribing physician. The parent or quardian of the student is to provide the school an emergency supply of the student's medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.    Physician's Signature	Dates to be given:	Allergies:			
PRESCRIPTION MEDICATION  Spiro Public School discourages the administration of medication to students in school if possible. This form will only be valid for the current school year. A new form is required yearly.  PLEASE USE A SEPARATE FORM FOR EACH MEDICATION  Medication:    Diagnosis:   Timde Name and/or Generic   Diagnosis:					
PLEASE USE A SEPARATE FORM FOR EACH MEDICATION  Medication:					
Medication:	form will only be valid for the current school y	year. A new form i	s required year	ly.	ible. This
Dosage:Time(s) to be given at School:					
Dosage:Time(s) to be given at School:	Medication:	Diagno	osis:		
Method of administration: ORAL					
Physician's Name (Please Print)  Physician or Representatives Signature  *** SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL  Provisions under 70 O.S. 1984, Section 1-1163, allow students to self administer prescribing physician. The parent or guardian of the student is to provide the school an emergency supply of the student's medication.  I have instructed	Method of administration: ORAL DLiquid	□Tablet □Inhale	DROPS	Eye R L	Ear R L
Signs and Symptoms   Can Medication be Repeated?   Yes   No   How Many Times?	Effective Dates: From/to	JJ_			
Signs and Symptoms   Can Medication be Repeated?   Yes   No   How Many Times?	Possible Side Effects:				
Prequency of Administration  Physician's Name (Please Print)  Physician or Representatives Signature  *** SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL  Provisions under 70 O.S. 1984, Section 1-1163, allow students to self administer prescribed asthmatic, diabetic, or allergic medication. Approval to self administer medications must be authorized by the prescribing physician. The parent or guardian of the student is to provide the school an emergency supply of the student's medication.  I have instructed					
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I have instructed	AUTHOR Provisions under 70 O.S. 1984, Section 1-1163	RIZATION/APPRO 3, allow students to sel	DVAL f administer pre	scribed asthmatic,	
and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.  Physician's Signature  TO BE COMPLETED BY THE PARENT/GUARDIAN  have read the procedure for medication administration (on the reverse side of this form) and I hereby request an uthorize Spiro Public School personnel to administer this medication as directed. I agree to release, indemined hold harmless Spiro Public School and any of their officers, staff members, or agents from lawsuit, claim lemand, or action against them for administering medication to this student. I understand that permission is granted for exchange of verbal and/or written communication between the school staff and the prescribing physician/dentist regarding this medication					
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Signature of Legal Parent/Guardian Date Contact Phone	Signature of Legal Parent/Guardian		_/	Contact I	Phone