MEDICATION PROCEDURES

A Parent's Handbook

Office of Strategic Planning & Support Services

Department of Student Services

2021-2022

Revised 06/2021

Policy 5330

Table of Contents

Contacts

If you have any questions or concerns about medications or School Health Services, please contact your child's Health Assistant or the Coordinators of School Health Services at the numbers below.

School	Health Room #
District Coordinator of School Health Services	564-5940
Assistant Coordinator of School Health Services	564-5947
Alternative Center for Education	564-6247
Beachland Elementary	564-3348
Citrus Elementary	978-8352
Dodgertown Elementary	564-4105
Fellsmere Elementary	564-5973
Gifford Middle	564-3570
Glendale Elementary	978-8053
Indian River Academy	564-3398
Liberty Magnet	564-5302
Osceola Magnet	564-5826
Oslo Middle	564-4025
Pelican Island Elementary	564-6499
Rosewood Magnet Elementary	564-3886
Sebastian Elementary	978-8259
Sebastian River Middle	564-5198
Sebastian River High	564-4282
Storm Grove Middle School	564-6338
Treasure Coast Elementary	978-8502
Vero Beach Elementary	564-4554
Vero Beach High School	564-5525
VBHS – Freshman Learning Center	564-5712
Wabasso	978-8005

Medication Procedures

The school board shall not be responsible for the diagnosis and treatment of student illness.

I**n order to assist students with medication, the following criteria must be met:**

- The administration of prescribed medication and/or medically-prescribed treatments to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program.
- The Medication Permission Slip is signed by the student's parent/legal guardian, prior to medication being accepted on campus.
- A recent photo of the student is submitted.
- The Physician's Authorization For Daily Medication and/or Physician's Authorization For As Needed Or Emergency Medication or other licensed healthcare provider order is provided.
- Medications must be in the original container with the student's name, dosage, directions for administration and current date.

For these purposes, **"medication"** shall include all medicines including those prescribed by a physician/health care provider and any non-prescribed (over-the-counter) drugs, preparations, and/or remedies, herbal products, cough drops, medicated throat lozenges and vitamin supplements.

Every school year a new prescription from the physician/health care provider must be obtained, along with a new health care provider order or Physician's Authorization For Daily Medication and/or Physician's Authorization For As Needed Or Emergency Medication along with a new Medication Permission Slip signed by a parent/guardian. Parents/guardian may bring up to a month's supply of medication to school. **Sharing of medication(s) is prohibited - including between siblings in the same school.**

Medication will be locked up in the health room at all times (with the exception of students with the authorization to self-carry). Notification will be made by phone or in writing (last

known address) to the parent/legal guardian to pick up outdated or discontinued medication.

Health Assistants/designated school personnel are authorized under Florida Statute 1006.062, to assist students with medication on school property provided that:

- They have completed a formal instructional class on assisting students with medication offered by the Coordinator of School Health Services and/or designated personnel.
- A Medication Permission Slip has been completed, signed, and dated by the student's parent/legal guardian.
- A recent photo, the Medication Permission Slip and either a healthcare providers order or the Physician's Authorization For Daily Medication and/or Physician's Authorization For As Needed Or Emergency Medications (forms included in this handbook). A prescription or pharmacy label is not a substitute for a healthcare provider order.

All of the above steps must be completed prior to the student having or receiving any medication during school hours or on field trips.

Medications meeting the above criteria must be supplied for the student and brought to school by the parent/legal guardian.

Prescription Medication

Prescription medication must be received in a pharmacy-labeled container with the following information:

- ✓ Student's name
- ✓ Physician/other appropriate practitioner and phone number
- ✓ Pharmacy's name and phone number
- ✓ Name of medication
- ✓ Dosage in milligrams
- ✓ Time of day to be taken (frequency--**as directed is not acceptable**)

- ✓ For specific symptoms if giving emergency medication
- ✓ Route of administration (by mouth, topical, injection)
- ✓ Duration of medication – Until change or stop order is received or until stop date noted on medication.
- ✓ A maximum of a 30-day supply will be accepted.

Students are **not** allowed to have medication in their possession on school property, on the school bus or while attending any school-sponsored activity *except* for emergency medication such as: asthma inhalers, epinephrine auto-injectors, diabetic testing/treatment supplies, and/or pancreatic enzymes or any other approved emergency medication prescribed for the student, by a physician.

In order to carry emergency medication, the following criteria must be met:

- ✓ A Medication Permission Slip has been completed and signed by the student's parent/legal guardian.
- ✓ Parental Authorization for Students to Carry and Self Administer Prescribed Medication(s) and Physician's Authorization For Daily Medication and/or Physician's Authorization For As Needed Or Emergency Medication form must be completed. (Forms are included in this handbook.)

Prescription medications that are past the pharmacy discard date or manufacturer's expiration date are considered expired medications. Expired or discontinued medication will be destroyed within 7 days after notification. **Any remaining medication at the end of the school year will be destroyed if not picked up by the last day of school.**

If a medication is lost and found, it will be destroyed.

Non-Prescription (Over-the-counter) Medication

Acetaminophen (Tylenol) may be given to *Middle and High School students* without a physician's order providing the following criteria are met**:**

- ✓ The Tylenol must be in an unopened bottle of 325mg or 500mg strength and brought in by the parent/guardian. No more than a small bottle of medication with 30 or less tablets will be accepted. Unit dose packages of acetaminophen are acceptable in lieu of bottled medication.
- ✓ An OTC Medication Authorization Form must be filled out and signed by the parent/guardian.
- ✓ A Medication Permission Slip must be filled out and signed by the parent/guardian.

(Forms are included in this handbook)

Any other non-prescription medication **must** have a doctor's order/prescription for use and a completed and signed Medication Permission Slip. It also must be received in its original container, unopened, and be labeled with the student's name. The only over-the-counter medications to be stored are those medically prescribed for specific students. Those medications will be kept in the locked medication cabinet in the health room.

Medical Equipment

If a student is required to use a wheelchair, crutches or the elevator due to injury or illness, a doctor's order is required and parent is to provide the crutches or wheelchair.

Discharge instructions from an emergency room visit that specify limitations will be accepted for a two week period unless otherwise specified by the ER physician. After the two week period, a physician's order will be required to continue treatment, including the use of crutches, wheelchairs, and/or an elevator pass due to injury or illness.

MEDICATION ADMINISTRATION DURING OFFICIAL SCHOOL BUSINESS

FIELD TRIPS: Prescription Medication Requirements

This procedure protects the safety and wellbeing of students who require medication administration by a trained staff in accordance with FL Statute 1006.062.

Medications are only permitted when failure to do so would jeopardize the health of the student.

This includes emergency medication such as epi pens, inhalers, pancreatic enzymes, diastat, diabetic supplies, Dramamine/or generic equivalent for motion sickness and/or necessary daily medication for a chronic medical condition.

- A completed Physician's Authorization Medication Form for each medication.
- All medication must be in the original container. The medication label must include: name of student, name of drug, dosage, time of day to be taken, name of the prescribing physician and a current date within the last year.
- Diabetic students attending school sponsored activities outside of school hours and/or overnight field trips require a completed Field Trip Diabetes Management Medication Form filled out by the student's healthcare provider.

THE FOLLOWING PROCEDURES MUST BE FOLLOWED

1. The Principal or his/her designee, of school-authorized activities/field trips, is responsible for notifying the Heath Assistant of a planned field trip as soon as they have a confirmed date.
2. A minimum of a 10 school-day notice is required to ensure that the school personnel have adequate time to receive child specific training to care for the student with special health needs.
3. Health assistant will copy the Medication Permission Slip for each student scheduled to go on a field trip. These copies may be used repeatedly throughout the year if all information remains the same.
4. Health Assistants are responsible for receiving ALL field trip medications (this includes day and overnight trips) from the parents.
5. Parents must bring in all necessary medication with corresponding Physician's Authorization for Medication Form within 5 days of field trip.

6. Health Assistants will ensure that all medication and paperwork is completed and stored in locked medication cabinet
7. Health Assistant to complete a pill count when accepting medications from the parent.
8. Trained staff member will be responsible for security of the medication and for medication administration.
9. Medication CAN NOT be administered by volunteer staff or parent chaperones.
10. If a parent/guardian attends the field trip with their child, the parent/guardian is responsible for supplying and administering their child's medication.

PRIOR TO DEPARTING ON FIELD TRIP

1. Trained staff member will meet with the Health Assistant to pick up the student's medication day of the field trip or evening prior.
2. Trained staff member will count and receive medication with the Health Assistant and document on medication log.
3. Medication will be kept in a secure location and out of reach of children.

DURING FIELD TRIP

1. Trained staff member will follow medication administration policy.
2. Medication to be kept on person or in a secure location, out of reach of children.
3. If medication not given, trained staff member will notify the parent, principal and the Health Assistant.

RETURN FROM FIELD TRIP

1. Upon return to school, the trained staff member will return medications to the Health Assistant.
2. The Health Assistant and trained staff member will review medication records and count the medications together and document on the medication log.
3. Health assistant will file the field trip medication permission slip in the medication book.
4. Medications will be secured and locked in the medication cabinet.
5. Parents are requested to pick up any leftover medication within 7 days upon returning from the field trip. Any medication not picked up within 7 days will be discarded.
6. If the medication is not given as ordered, the staff responsible for giving the medication on the field trip will document the variance on the Medication Error

Form. The Medication Error Form is completed and the Health Services Coordinator is contacted and the form is sent for review.

ADMINISTRATION OF EMERGENCY MEDICATIONS DURING SCHOOL-SPONSORED EVENTS HELD OUTSIDE NORMAL SCHOOL HOURS

It is the parent's responsibility to notify their school's health assistant and school personnel staffing the school-sponsored event, who will notify the school's RN, that their child is enrolled in a school-sponsored event before or after school. Parents must provide school personnel a recent photo, the Medication Permission Slip and Physician's Authorization For Daily Medication and/or Physician Authorization For As Needed Or Emergency Medication (forms included in this handbook).

School personnel staffing school-sponsored events before and after school may be taught child-specific medication administration procedures, by the school's assigned RN, for children who may require emergency medication while under their care. Emergency medications include, but are not limited to, asthma medications, Glucagon, Diastat and EpiPen®.

For those students who may require emergency medication in these situations, the school RN will include the procedure for emergency medication administration in the student's Individual Health Plan. The procedure will be student specific, based on the child's age and ability to self-manage their illness.

The staff person, trained in medication administration, accompanying the student will be responsible for security of the medication and for medication administration unless the student has a Parental Authorization for Student to Carry and Self Administer and a Physician's Authorization For Daily Medication and/or Physician Authorization For As Needed Or Emergency Medication on file in the health room (forms included in this handbook).

Appendix A: Medication Forms

See Medication Inspection checklist. If all criteria is not met, medication cannot be accepted.

SCHOOL DISTRICT OF INDIAN RIVER COUNTY

MEDICATION PERMISSION SLIP SCHOOL YEAR 20___ TO 20___

PLACE CURRENT STUDENT PHOTO HERE

- ☐ Completed Health & Wellness Form
- ☐ Completed Physicians Authorization
- ☐ Student Photo
- ☐ Medication in Health Room
- ☐ Student Self Carry
- ☐ Both
- ☐ IHP

Pharmacist: Place duplicate label to prescription (bottle) here

ALLERGIES: _____

I hereby request and give my permission for district school board personnel to assist my child with medication administration as prescribed by my child's medical provider, and in accordance with FL Statute 1006.062, the district health services manual and the approved School Health Services Plan. I understand that medical information related to the care of my student during the instructional day or while away on school sponsored field trips will be shared with school staff on a need to know basis. I also understand that this medication will be disposed of on the last day of the current school year or when expired UNLESS picked up by parent/guardian.

Parent/Guardian Signature: _____ Daytime Phone: _____ Date: ____/____/

STUDENT NAME_____ID#_____DOB_____/_____/_____GRADE_____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUG	**Time/ Initials**																															
	Time/ Initials																															
SEPT	**Time/ Initials**																															
	Time/ Initials																															
OCT	**Time/ Initials**																															
	Time/ Initials																															
NOV	**Time/ Initials**																															
	Time/ Initials																															
DEC	**Time/ Initials**																															
	Time/ Initials																															

KEY: A-absent D-early dismissal F-field trip L-late M-missed dose O-out of meds R-refused W-Withheld *(document reason)* **X-no school**

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN	**Time/ Initials**																															
	Time/ Initials																															
FEB	**Time/ Initials**																															
	Time/ Initials																															
MAR	**Time/ Initials**																															
	Time/ Initials																															
APR	**Time/ Initials**																															
	Time/ Initials																															
MAY	**Time/ Initials**																															
	Time/ Initials																															
JUN	**Time/ Initials**																															
	Time/ Initials																															
JUL	**Time/ Initials**																															

SIGNATURE KEY OF PERSON ASSISTING STUDENTS WITH MEDICATION

Name:	Initials	Name:	Initials	Name:	Initials
Name:	Initials	Name:	Initials	Name:	Initials
Name:	Initials	Name:	Initials	Name:	Initials

For new supply of medication, See Medication Log

***Medication Pick up/or Wasted: Date: _____ Medication Count: _____Parent Signature: _____ Staff or Witness Signature_____**

STUDENT NAME: _____ID#_____ Grade _____-

KEY: A-absent D-early dismissal F-field trip L-late M-missed dose O-out of meds R-refused W-Withheld *(document reason)* **X-no school**

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

For Over-the-Counter (OTC) Medication

(Middle School and High School Students ONLY)

Instructions: Please return this completed form to the school health room.

Student's Name_____ D.O.B._____ ID#_____

School Name_____ Grade_____

Students Allergies_____

I grant permission to the principal or his/her designee to assist in the administration of this over-the-counter medication to my child while in school. I will supply the named medication in an unopened, original store-issued container. I understand that it is my responsibility to hand carry medication to the school health room. (**DO NOT send medication to school with your child.**) I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand that I will be notified when the medication is given. I understand that, according to F.S 1006.062, that there shall be no liability of civil damages as a result of the administration of the medication when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.

***Reason for Medication:** _____

Mark only one box below. (No other medications have been approved.)

☐ Acetaminophen (Tylenol) Regular Strength	(One) 325mg (regular strength) tablet every 4 hours as needed.
☐ Acetaminophen (Tylenol) Regular Strength	(Two) 325mg (regular strength) tablets every 4 hours as needed.
☐ Acetaminophen (Tylenol) Extra Strength	(One) 500mg tablet every 4 hours as needed.

Parent/Guardian Name (*print*) _____ Date: _____

Parent/Guardian (Signature required)_____Date: _____

Emergency Phone #_____Home Phone #_____

Business Phone #_____Cell Phone #_____

Physical Address_____

Medication request reviewed by Health Services RN or Health Department RN
RN Signature_____ Date_____

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

PHYSICIAN'S AUTHORIZATION FOR AS NEEDED OR EMERGENCY MEDICATION
SCHOOL YEAR 20___TO 20___

Name of Student _____ DOB _____

The above named student is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment. I am aware that trained non-medical staff may assist the student with this physician prescribed medication or treatment.

ONE MEDICATION PER FORM

Diagnosis/ICD 10 Code: _____

Allergies: _____

Medication name: _____ Dosage: _____

Route: _____ Schedule: _____
(Interval Between Doses)

(_____)

SPECIFY SYMPTOMS ABOVE FOR WHICH THE STUDENT IS TO TAKE THE MEDICATION
(i.e. cough, wheezing, shortness of breath, headache, orthodontic discomfort, etc.**)**

For Asthma Inhalers or Epinephrine Auto-Injectors ONLY

Student has been instructed in proper use of an asthma inhaler Yes ☐ No ☐

Student has been instructed on how to self-administer an auto-injector Yes ☐ No ☐

Student is competent to carry and self-administer this medication at school and while away on school sponsored activities Yes ☐ No ☐

SPECIAL INSTRUCTIONS

_____

_____

_____	_____	_____	_____
Healthcare Provider (Print Name)	Healthcare provider Signature	Office phone number	Date

Print or Stamp with Office Address

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

PHYSICIAN'S AUTHORIZATION FOR DAILY MEDICATION
SCHOOL YEAR 20___ to 20___

Name of Student _____ **DOB** _____

The above named student is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment. I am aware that trained non-medical staff may administer this physician prescribed medication or treatment.

ONE MEDICATION PER FORM

Diagnosis/ICD 10 Code: _____

Allergies: _____

Medication name: _____ Dosage: _____

Route: _____ Schedule: _____
(Interval Between Doses)

Time to be administered during school hours: _____
(Must be time specific)

SPECIAL INSTRUCTIONS

_____

_____

_____

_____	_____	_____	_____
Healthcare Provider (Print Name)	Healthcare Provider Signature	Office phone number	Date

Print or Stamp With Office Address

School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

Parental Authorization for Students to Carry and Self-Administer a Prescription Inhaler, EpiPen, Insulin, or Other Approved Medication School Year 20___ to 20___

_____ (student) needs to carry the following prescription labeled inhaler, Epipen, insulin, and/or _____ prescription medication with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

We strongly encourage each student to keep a second prescription inhaler, Epipen, additional insulin or other prescribed medication in the school health room in case of emergency and in the event the first is lost or left at home.

PARENT/GUARDIAN SECTION

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school and on field trips: _____.

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above name student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Indian River County School District and its employees of any legal responsibility when the above named student administers his/her own medication.
- Completion of this form authorizes Student Health Services to discuss this medication order/request with the prescribing provider if indicated.

_____	_____	_____
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

STUDENT SECTION

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication under any circumstance. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept the responsibility for notifying the Health Assistant each time I take my medication.

_____	_____	_____
Student's Signature	ID #	Date