RCSS AUTHORIZATION TO GIVE MEDICATION AT SCHOOL - Pro-Longed Time Period

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student: _____ School: _____

Homeroom Teacher: _____ Grade: _____

I request that _____ School, through the principal or designee to supervise/assist in the administering of medication to my child according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacies can provide a duplicate labeled container with only the school doses.
- Parent/Guardian must provide special instructions, as well as the medication and related equipment, to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medications will be taken directly to the office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of medication: _____ Dose: _____

Route (mouth, topical, etc.): _____ Time(s) to be given: _____

Terminate medication on: _____

Physician's PRINTED Name: _____ Physician Phone: _____

Condition/Illness requiring medication: _____

Possible side effects, if any: _____

What to do in a case of side effect(s): _____

Allergies: Food: _____ Medication(s): _____

Signature of health care provider: _____ Date: _____

I hereby authorize the school personnel, employees and officials of the Richmond County School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medication, I am responsible for completing a new request form.

Parent Signature & Date: _____

SERVICE PLAN for SCHOOL-BASED MEDICAID SERVICES

1. My child is eligible for Medicaid or Peach Care YES___ NO___ Number _____
2. **My child is receiving Special Ed. Services YES __ NO__ Nursing is in the IEP _____ Other Health Plan _____**

I understand that the school district is able to file with Medicaid or Peach Care for partial reimbursement for the administering of this medication or procedure. By signing below, I give my consent for the school district to receive this payment from Medicaid or Peach Care.

I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of medicating/treating my child at school. I may change/withdraw permission in writing at any time by notifying the Special Education Director or School Nurse

The undersigned authorizes the prescribing physician named below to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize the Richmond County Schools to release pertinent information to the physician.

Parent/Guardian Signature & Date: _____

Written Authorization for Self-Administration of Asthma Medication by Minor Children at School

Student Name: _____ Date of Birth: _____ Grade: _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of asthma medication by this student while in school, at a school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school-operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and asthma devices.
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medication.
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of asthma medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered asthma medication.
- ensuring the student always carries his/her asthma medication on his/her person.
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- informing school staff in writing of any changes in the student's treatment or asthma management.
- informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information.
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- coordinating distribution of the student's asthma management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the School System and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/ her asthma medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

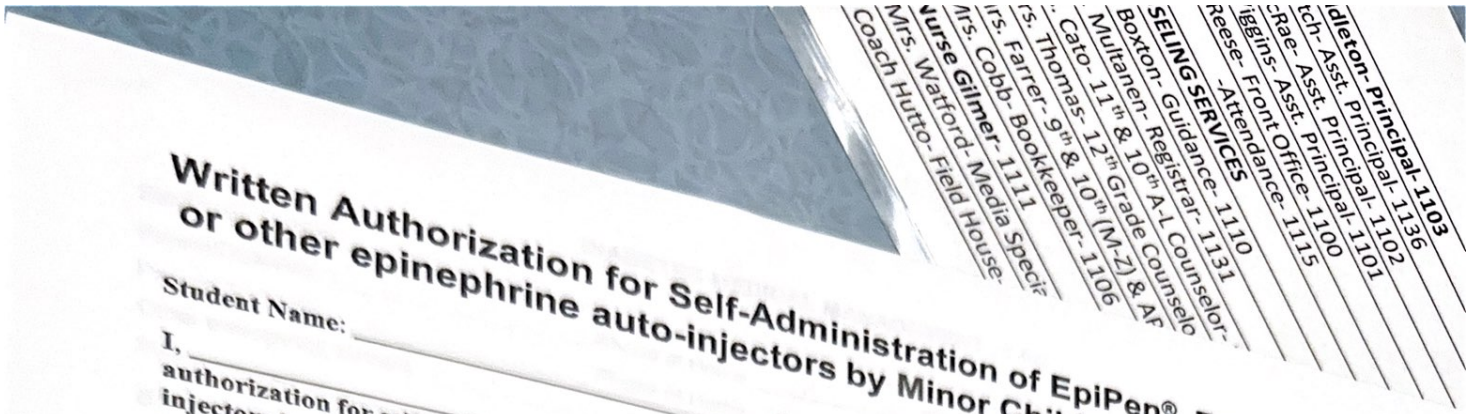
_____ _____

Student's Signature Date

The above-named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

_____ _____

Healthcare Provider Signature Date



Written Authorization for Self-Administration of EpiPen®, EpiPenJr.® or other epinephrine auto-injectors by Minor Children at School

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of EpiPen® and EpiPenJr.® or other epinephrine auto-injectors by this student while in school, at a school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school-operated property. The student demonstrates full understanding of the proper use of his/her allergy medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his/ her allergy medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty allergy medication and allergy devices.
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with allergy medication.
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of allergy medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of allergy medication, medication use, and refilling of prescriptions for allergy medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered allergy medication.
- ensuring the student always carries his/her allergy medication on his/her person.
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- informing school staff in writing of any changes in the student's treatment or allergy management.
- informing the school of any allergy exacerbations, hospital visits, and/or new or changed student medical information.
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- coordinating distribution of the student's allergy management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the School System and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/ her allergy medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student have been instructed in the proper use of my prescription allergy medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above-named student has been instructed and demonstrates understanding of the proper use of his/her allergy medication. It is my professional opinion that the student be permitted to carry and self-administer his/her allergy medication. I have provided the parent/guardian with a written allergy emergency/management plan including the name, purpose, dosage, and administration directions of the allergy medication.

_____ _____