TOWN OF NORTH PROVIDENCE SCHOOL DEPARTMENT
MEDICATION PROCEDURE

NOTE: Parents are encouraged to give medication at home and on a schedule other than during school hours.

If it is necessary that a medication be given during school hours, the following regulations must be followed:

1. A parent or guardian is required to bring the medication to school.

2. Only medication prescribed/advised by a physician/dentist will be given. One completed medication form is necessary to be filled out annually by your physician for each medication prescribed.

3. All medication brought to school must be in the original prescription container, accompanied by a properly executed copy of this medication authorization and consent form, and include the following information:

    a. Student's name
    b. Name and dosage of medication
    c. Instructions for administration
    d. Physician's name, signature and license number

4. Only one (1) dose of medication per day will be given in school. Medication that is required more than once will not be given in school unless directly ordered by a physician.

5. ALL medications will be kept in a locked medication area. It is the expectation of the School District that the dispensation of medications in the school shall be supervised by the certified school nurse/teacher. The certified school nurse/teacher, student's parent/guardian or parent designee will administer medications.

EXCEPTIONS: Students with physician's orders for the use of an Epi-Pen, Epi-Pen Jr., asthma inhalation device or other emergency medication shall be readily available to the student. The certified school nurse/teacher shall develop an individualized plan to instruct such students in the proper use and method of self-administration of his/her individually prescribed medication. In the event of an incident where the child is unable to attend to his/her own needs, the principal/attending staff member shall be authorized to act in loco parentis. A daily record keeping system will be maintained by the certified school nurse/teacher.

6. Authorization for medication dispensation must be received for each medication and is effective only for the length of time stated by the physician/dentist, but no longer than the current school year.

7. If the student is to go on a field trip, the parent/guardian or parent designee must make arrangements through the school regarding medication, i.e. Parents are welcome to attend field trips, omit or reschedule dosage for that day.

NO MEDICATION WILL BE GIVEN UNLESS THE ATTACHED FORM IS FILLED OUT AND SIGNED BY THE PARENT AND PHYSICIAN/DENTIST AND THE ABOVE REGULATIONS ARE MET. COMPLETED CONSENT FORMS WILL BE PLACED ON FILE IN THE STUDENT'S HEALTH RECORD.

TOWN OF NORTH PROVIDENCE SCHOOL DEPARTMENT
MEDICATION AUTHORIZATION AND CONSENT FORM

A Certified School Nurse/Teacher has permission to administer the medication prescribed below to my child

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

The school physician and/or nurse teacher has permission to discuss medical issues with the prescriptive issuing physician/dentist.

____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.

_____ _____ _____ _____

Parent/Guardian Signature *Date* *Home Phone* *Work Phone*

Physician/Dentist Medication Information
(The following is to be completed by the physician/dentist)

Diagnosis for which medication is given: _____

Name of medication: _____

Form of Medication *(e.g. liquid, tabs, etc.)* _____ Dosage _____

Time to be given: _____ If medicine is to be given "when needed", describe indications:

_____

Length of time medication is to be taken: _____ Expiration Date: _____

Significant side effects: _____

May the student self-administer and carry his/her inhaler : __Yes __No

If the child is on a field trip, may medication be omitted: __Yes __No

Hospital child should be transported in case of emergency: _____

Other information: _____

_____ _____ _____ _____

Physician/Dentist's Signature *License No.* *Date* *Phone No.*

Please note: Medicine will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.

TOWN OF NORTH PROVIDENCE SCHOOL DEPARTMENT
MEDICATION AUTHORIZATION AND CONSENT FORM

A Certified School Nurse/Teacher has permission to administer the medication prescribed below to my child.

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

The school physician and/or nurse teacher has permission to discuss medical issues with the prescriptive issuing physician/dentist.

____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.

_____ _____ _____ _____

Parent/Guardian Signature *Date* *Home Phone* *Work Phone*

Physician/Dentist Medication Information

(The following is to be completed by the physician/dentist)

Diagnosis for which medication is given: _____

Name of medication: _____

Form of Medication *(e.g. liquid, tabs, etc.)* _____ Dosage _____

Time to be given: _____ If medicine is to be given "when needed", describe indications:

_____

Length of time medication is to be taken: _____ Expiration Date: _____

Significant side effects: _____

May the student self-administer and carry his/her inhaler : __Yes __No

If the child is on a field trip, may medication be omitted: __Yes __No

Hospital child should be transported in case of emergency: _____

Other information: _____

_____ _____ _____ _____

Physician/Dentist's Signature *License No.* *Date* *Phone No.*

Please note: Medicine will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.