HENDERSON COUNTY PUBLIC SCHOOLS

MEDICATION ADMINSTRATION FORM

Per HCPS School Board Policy 6125/Rev. 6/2024

School: _____

Teacher/Grade: _____ _____

School Year: _____

Date Reviewed & Approved/School Nurse's Signature: _____ _____

SECTION 1: PARENT/GUARDIAN CONSENT

Student's Full Name: | **Date of Birth:**

- I hereby give authorization for my child to receive medication during school hours as directed below.
- I give permission for the release and exchange of medical information between my child's physician, school nurse, and HCPS that is necessary in carrying out services for my child.
- On behalf of my child, I release the HCPS School Board and their agents and employees from any and all liability that may result from my child taking this medication at school.
- I understand it is my responsibility to bring this medication in the original pharmacy labeled container and original packaging to the school.
- Any medication that is not picked up by the end of the school year will be discarded.

Parent/Guardian Signature: | **Phone Number:** | **Date:**

SECTION 2: LICENSED HEALTHCARE PROVIDER AUTHORIZATION

Medication Name: | Route: | Medical Diagnosis:

Dosage/Instructions:

Time/Frequency:

☐ **PRN:**
Emergency Action Plan Attached

To be given from:
(Date) _____ To _____

(Authorization is valid for current school year only.)

Possible Reactions or Side Effects:

Student Self-Medicates:

☐ Check box if student understands the use of emergency medication and has been instructed on how to self-administer.

I hereby certify that it is necessary for this student to receive this medication during school hours.

Signature of Health Care Provider: _____ **Date:** _____

Stamp, Print, or Type Health Care Provider's Name, Address, Phone, & Fax:

SECTION 3: MEDICATION INVENTORY LOG

Date	Medication	Amt	Received By: Signature(staff)	Received From: Signature(parent)	Returned To: Signature(parent)	Returned By: Signature(staff)

Disposed of Medicine: Date: _____ Nurse: _____ Witness: _____

Medication Administration Procedures:

It is the policy of the Henderson County Public Schools to have written authorization for a student to take any medication during the school day. In accordance with School Board Policy 6125, the following conditions must be met before school staff are permitted to administer to medication at school:

- A **Medication Administration Form** must be completed and **signed by both the Parent/Guardian and the Licensed Health Care Provider for any over the counter or prescription medications** that must be given to maintain and support the student's presence at school.
- **Medication must be brought to school by a responsible adult in a clearly labeled pharmacy container.** If the medication is available over-the-counter, it must be provided in the original container or packaging, labeled with the student's name.
- **All school personnel who will be administering medications must receive appropriate training.**
- Appropriate staff will be made aware of your child's condition and need for medication. In accordance with FERPA and state confidentiality laws, **all written information maintained by school personnel must be kept confidential and can be shared only on a need to know basis.**

SELF-ADMINISTRATION OF MEDICATION

- Before a student can **self-administer an emergency medication at school there must be written consent from the parent and a written statement from the health care provider verifying:**
  - the student has diabetes, asthma, or an allergy that could result in anaphylactic reaction;
  - the health care practitioner prescribed the medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events; and
  - the student understands the use of the medication, has been instructed in self-administration of the medication, has demonstrated the skill level necessary to use the medication and any accompanying device, and has been determined to be competent for self-administration;
- Prior to being permitted to self-administer medication at school, **the student also must demonstrate to the school nurse** (1) the skill level necessary to use the medication and any device necessary for its administration; and (2) sufficient knowledge and maturity to be independent in the management of the medication with no oversight from school staff.
- The **student's parent must provide backup medication to the school.** School personnel are to keep in a location to which the student has immediate access in the event the student does not have the required medication.

STUDENT RESPONSIBILITY

- A student who uses his or her medication in a manner other than as prescribed or who permits another person to use the medication may be subject to disciplinary action pursuant to the school disciplinary policy. However, school officials shall not impose disciplinary action on the student that limits or restricts the student's immediate access to the diabetes, asthma, or anaphylactic medication.
- The board does not assume any responsibility for the administration of medication to a student by the student, the student's parent, or any other person who is not authorized by this policy to administer medications to students.
- HCPS School Board Policy 6125 is available at: https://www.boardpolicyonline.com/bl/?b=henderson_county

HENDERSON COUNTY PUBLIC SCHOOLS

Contract for Self-Carried Medication

Student: _____ DOB: _____ Teacher/Grade: _____
Physician: _____ Phone: _____
Medication _____ Dose: _____ Time: _____

SECTION 1: PARENT/GUARDIAN AUTHORIZATION

My child is capable of self-medication and meets the HCPS eligibility requirements. I give consent to HCPS to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. I will support my child to follow the agreement below and if he/she does not, I will be contacted and we will develop a new plan. I agree to provide a backup supply of the medication to be kept at school if needed. I release the HCPS School Board, their agents and employees from any and all liability that may result from my child carrying or taking this medication at school.

Parent/Guardian Signature:	**Phone:**	**Date:**

SECTION 2: STUDENT /SCHOOL NURSE CONTRACT

Responsibilities for Carrying Medication Observed

Yes No
____ ____ Health care action plan complete
____ ____ Demonstrated correct use/administration
____ ____ Recognizes proper and prescribed timing for medication
____ ____Does not share medication with others
____ ____ Keeps medication in agreed location
____ ____ Agrees to come directly to the Health Office if having the following symptoms after using medication: _____
____ ____ Keeps a second labeled container in the Health Office.

The student does/does not demonstrate the specified responsibilities. The student may/may not carry the medication unless and until he/she fails to follow the above agreement.
Comments and added responsibilities: _____

Student Signature:	**School Nurse Signature:**	**Date:**