

WTSD Medication Administration Guidelines

The procedure for the administration of medication is in alignment with District Policy 5330. The NJ DOE defines medication as a drug approved by the FDA for preventing, caring for, and assisting in the cure of disease and injury that has a written order from a physician licensed in medicine, dentistry, or osteopathy, or from an advanced practice nurse. Medication may include, but is not limited to, nutritional supplements, cough drops, acetaminophen/ibuprofen, eye drops, nasal sprays and topical ointments. Medication does not include herbal remedies.

1. The school nurse shall supply the parent/guardian of any pupil requiring medication at school with the necessary Medication Request forms.
2. ALL completed Medication Request forms shall be returned to the nurse and filed in the Health Office.
3. Medication will be administered to a student only with a written, signed statement from the physician and parent/guardian which includes the name of the medication, the purpose of its administration to the specific pupil for whom it is intended, its proper timing and dosage, and the date when its use should be discontinued. Also included in the physician's request will be its possible side effects and its usage during class trips.
4. The written documentation from the physician is the responsibility of the parent/guardian.
5. Medication in its original, labeled container **MUST BE** delivered by the pupils' parent/guardian to the school nurse. **Students are NOT permitted to bring medication to school or carry it with them on the school bus or on school premises.**
6. When any changes occur in the type, dosage and/or time of the medication during the current school year, the said change **MUST BE** accompanied by updated forms. This includes an order to discontinue medication before the specified end date.
7. If a medication needs to be discontinued or dosage changed prior to the original date for any reason, the school nurse may take a verbal order from a physician, which **MUST** be followed with a physician's written order within 48 hours.
8. Medication is stored in a secured locked space.
9. The Pupil Medication form(s) shall be maintained by the school nurse on each pupil receiving medication in school. At the end of the school year the medication order will be placed in the student health file.
10. Medication shall only be administered by the school nurse, school physician, substitute school nurse employed by the district, the student's parent/guardian or student who is approved to self-administer.
11. Medication shall be picked up by the parent/guardian at the end of the school year or when the medication is discontinued, whichever is earlier. If it is not picked up by the parent/guardian, it will be discarded by the school nurse five days after it has been discontinued or on the last day of school.
12. All medication requests are effective for one school year only and must be renewed annually.

INHALERS/EPI-PENS self-medication may be permitted for students with asthma or other potentially life-threatening illnesses with proper documentation from the physician and parent/guardian. Kindly contact your school nurse to discuss your student's needs for inhalers, epi-pens, and/or an antihistamine (if indicated).

Brass Castle Health Office Phone #: 908-689-1188 ext. 3607 & Fax #: 908-689-2356

Port Colden Health Office Phone #: 908-689-0681 ext. 2507 & Fax #: 908-689-8584

Each Health Office has a supply of calamine lotion, ointment or first aid cream for scrapes, and allergy drops. Please note that sunscreen is not allowed to be brought to school but should be put on the child before they come to school in the morning, if needed.



HEALTHCARE PROVIDER AUTHORIZATION FOR MEDICATION

(Authorization valid for current school year 20__ - 20__)

Student: _____

DOB: ___/___/___

→ Provider: Please complete this section. Signature, Address, Date, and Stamp are required.

It is necessary for this child to receive the following medication during school hours:

Medication: _____
Administration Start Date: ___/___/___ Discontinue Date: ___/___/___
Dose & Route: _____ Administration Time(s): _____
Diagnosis: _____
Adverse Reactions/ Side Effects that may occur: _____

CLASS TRIPS: When a parent/guardian is unable to attend a class trip (please check one):

- The dose can be withheld on the day of the class trip
The time of administration can be adjusted with the parent/guardian

Healthcare Provider Signature

Date

Healthcare Provider Printed Name

Office Address and Phone Number

OFFICE STAMP

→ Parent/Guardian Request Section: Please read and sign/date

I give permission to the school nurse to administer medication to my child as prescribed above. I also give permission for the exchange of information between the school nurse and my child's healthcare provider concerning my child's health and treatment.

- Yes, I want medication to be given on early dismissal (half) days.
No, I do not want my child to be given medication on early dismissal (half) days.

Parent/Guardian Signature

Date