

A. Middle School. The following rules apply to the use, application, and transportation of all medications at the middle school levels.

1. **Non-Prescribed Medication.** A Parental Medication Authorization form must be signed by the student's parents or guardian permitting the use of non- prescribed medication.
2. **Prescribed Medication.** The student's parents or guardian must provide the school nurse with a written order of a physician, physician assistant, or advanced practice registered nurse that prescribes the type and amount of medication. In addition, a Parental Medication Authorization form permitting the use of medication must be signed by the student's parents or guardian and filed with the school nurse. *Middle school students may self-carry and use inhalers with written parent authorization to the school office.* Students are prohibited from transferring, delivering, or receiving any medication to or from other students.
3. **Taking of Non-Prescribed and Prescribed Medication.** The taking of non-prescribed and prescribed medications, shall be performed under the direct supervision and observation of the school nurse or health room paraprofessional.
4. **Transporting Medications to and from School.** Middle school students will not be allowed to transport prescribed medications to and from school. *Prescribed medications* must be transported by the student's parents or guardian or by an adult designated in writing by the parents or guardian (with the exception of self-carry inhalers). *Non-prescribed medications* may be transported by middle school students to and from school but must be delivered to the school nurse or health room paraprofessional.

B. High School. The following rules apply to the use and application of medications at the high school level.

1. **Non-Prescribed Medication.** No Parental Medication Authorization form is required for non- prescribed medication. **All** medication shall be kept in its original container with its original label which describes the ingredients of the contents, recommends dosages, and provides appropriate warnings. Students are prohibited from transferring, delivering, or receiving any medication to or from other students.
2. **Prescribed Medication.** The student's parents or guardian must provide the school nurse with a written order of a physician, physician assistant, or advanced practice registered nurse that prescribes the type and amount of medication. In addition, a Parental Medication Authorization form permitting the use of medication must be signed by the student's parents or guardian and filed with the school nurse. The medication shall be delivered to the school nurse.
3. **Transporting Medications to and from School.** High school students will not be allowed to transport prescribed medications to and from school. High school students may self-carry and use inhalers with parent written authorization to the school office. Prescribed medications must be transported by the student's parents or guardian or by an adult designated in writing by the parents or guardian.

VISITING NURSE HEALTH SERVICES
SCHOOL HEALTH PROGRAM
MEDICATION AUTHORIZATION

Student _____ Grade ____ Age ____ School _____

PHYSICIANS DIRECTIONS

Medication to be given _____

Dosage _____ Route _____ Time _____

Starting date _____ Termination date _____

Purpose of medication _____

Possible side effects/observations to note _____

Physician requests comments from school? Yes _____ No _____

This medication may be safely given by an unlicensed individual who has demonstrated competency in medication provision.

Physician Signature _____ Phone _____ Date _____

I request the student above receive the medication as ordered by the physician while in school and school related activities. I understand it is my responsibility to furnish the medication in the original container or prescription bottle appropriately labeled by the pharmacy or physician stating name of medication, dosage and instructions. I accept the responsibility of monitoring the action and side effects of the medication and ask that I be notified if the following occurs:

Parent/Guardian Signature _____

Address _____

Phone _____ (home) _____ (work) _____ (other)

Complete this section in addition, ONLY if medication is PRN/as needed:

Medication should be provided when: _____

Notify if additional instructions: _____

I find the following unlicensed individual(s) competent to provide the medication stated above: _____

Parent Signature _____ Date _____