Medication Administration Protocol

for requests outside of Nursing Support Services Care Plans

(TO BE COMPLETED FOR **EACH** MEDICATION TO BE GIVEN)

Student Legal Name: _____ **Grade:** _____

Date of Birth: _____ **PEN:** _____

PHN#: _____ **School:** _____

☐ Physician Prescribed
(all sections to be completed)

☐ Over the Counter (OTC) / Non-Prescription
(complete sections A and C)

Section A

Name of Medication: _____

Medication expiration date: _____ Time(s) to be administered: _____

Dosage: _____ Frequency: _____ Route: _____

Location at the School: _____

Medication to be administered to address the following symptoms:

1. _____
2. _____
3. _____
4. _____

Other: _____

Additional comments *(e.g., possible reactions, what to do if a dose of medication is missed etc.)**:*** _____

_____

_____

Procedures to deal with a problem (e.g., call parent, emergency contact, 911)

1. _____
2. _____
3. _____
4. _____

Other medications student is receiving: _____

Section B

Medical Condition / DX: _____

Intended effect of the medication: _____

Doctor's name, phone and emergency contact information: _____

_____

Physician's Signature: _____ Date: _____

Section C

Parent to initial each statement*:*

_____ I am aware of Board Policy and Regulation on the Treatment of Students with Medical Problems.

_____ I agree that the above information is correct.

_____ I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's directions for use, including dosage.

_____ I authorize the staff of School District 36 (Surrey) and its agents to administer the designated medication and to obtain suitable medical assistance if required.

_____ I am aware that no medication will be administered until this form is completed and returned.

_____ I am aware that staff working with my child may need to know of my child's condition and of the medication required.

_____ I am aware I am required to update this information each September, or as any changes occur during the year.

_____ _____

Signature of Parent/Guardian *Date*

For School Use only - to be completed by school staff

Name of person administering medication outside of Nursing Support Services delegated care plan criteria:

_____ _____

Please print *Signature*

☐ Approval for Self-administration: _____

☐ Approval for student to carry emergency medication on their person (e.g., Inhaler, EpiPen, Glucagon): ____

_____

Date (yyyy-mm-dd) this information was provided: _____

Date (yyyy-mm-dd) this information was reviewed by Parent/Guardian: _____

Each staff member who is responsible for the administration or supervision of the medication must review the information on this form then date and print and initial below:

Print name: _____ Initial: _____ Date: _____

Print name: _____ Initial: _____ Date: _____

Print name: _____ Initial: _____ Date: _____

Print name: _____ Initial: _____ Date: _____

Copies: ☐ *Parents* ☐ *Student File* ☐ *Medical Alert* ☐ *Binder* ☐ *TOC File* ☐ *MyEd BC*