

NORTHERN LEBANON SCHOOL DISTRICT
Policy 210: MEDICATION POLICY - Prescription and Over-the-Counter

It is preferred that medication be administered during the school day and activities only when failure to take such medicine would jeopardize the health of the student or the student would not be able to attend school if the medicine were not available. The use of medication will be permitted under the following conditions:

1. The physician's order and medication must be delivered upon entry to school property to the school nurse or main office. Unless the student is granted permission for self-medication (see #3), medication may not be kept in desks, pockets, lunch bags, lockers, etc.
2. An order must be completed for each medication, prescription or over-the-counter. One form will be good for the entire school year, providing there are no changes.
3. With physician, parent/guardian, and school nurse permission, a student may self-medicate and carry medication. A criteria checklist will be used by the nurse to determine permission for self-medication.
4. The medication must be in the original container and be clearly identified.
5. **A physician signature is REQUIRED for ALL prescription and over-the-counter medications.**
6. The student shall be responsible for going to the nurse's office for his/her medication at prescribed times. The school personnel are not responsible for assuring self-administrated medications are taken daily.
7. At the end of the school year, unused medication shall be removed from school by the parent/guardian or designee. If not removed the medication will be discarded by the nurse.

REQUEST FORM FOR STUDENT TO RECEIVE MEDICATION DURING SCHOOL DAY

Student: _____ **Birth date:** _____

Medication: _____ **Route:** _____

**Side effects/
contraindications** _____

**Emergency
response:** _____

Diagnosis: _____

Dosage: _____ **Effective date:** _____ **to** _____

Hour(s) or times(s) to be distributed: _____

_____ **Physician please initial if student is qualified and able to self-administer and carry medication. (see criteria in #3 above)**

Date: _____ **Requested
by:** _____
Physician/Physician Designee Signature

Physician Address

Physician Contact Phone Number

As parent/guardian I hereby release the Northern Lebanon School District and all its employees from any and all liability regarding the administration of medication and for the benefits or consequences of the medication. I request the school complies with the order of physician/ physician designee (signature below).

_____ Initial if parent/guardian requests self-administration and understands that the school and employees bear no responsibility for assuring the self-administered medication is taken and relieves district and its employees of responsibility for the benefits or consequences of the prescribed medication (signature below).