Lynden Christian Schools/Evergreen Christian School

GUIDELINES FOR PARENT/GUARDIAN REGARDING ORAL MEDICATIONS AT SCHOOL

Lynden Christian Schools is authorized by RCW 28A.210.260-270 and RCW 18.71.030 (3) to administer prescribed oral medication to students during school hours or while students are under the supervision of Lynden Christian Schools personnel. Lynden Christian Schools will authorize its employees to administer prescribed oral medication to students ONLY when the student requires such medication in order to attend school, or when the student is susceptible to a predetermined life-threatening condition.

IF MEDICATION IS TO BE GIVEN AT SCHOOL, THE FOLLOWING MUST BE FOLLOWED:

1. An *AUTHORIZATION FOR MEDICATIONS AT SCHOOL* form for each medication prescribed is to be completed and signed by the child's physician for prescription and over-the-counter medication. The form must also be signed by the parent or guardian. For students in grades 9-12, if medication is over-the-counter an AUTHORIZATION FOR MEDICATIONS AT SCHOOL form need **only** be completed and signed by a parent or guardian (no physician signature is needed).
2. An *EMERGENCY PLAN FOR BEE STINGS AND ALLERGY/ANAPHYLAXIS* form for epinephrine and antihistamines prescribed for a life-threatening allergy must be completed and signed by the child's physician. The parent portion of the *EMERGENCY PLAN FOR BEE STINGS AND ALLERGY/ANAPHYLAXIS* form must also be signed by the parent or guardian.
3. Students will be allowed to self-carry/self-administer their epinephrine injectors or inhalers at the discretion of their physician, this must be indicated on the medication form. Students in grades 9-12 will be allowed to self-carry/self-administer oral medications if indicated by the physician (prescription) or parent (over-the-counter). **STUDENTS MAY ONLY CARRY A ONE DAY SUPPLY OF MEDICATION.**
4. The medication must be furnished in an original container from the pharmacy with the student's name, the name of the medication, and the amount to be given. Over-the-counter medication must be furnished in the original container from the manufacturer. All medications must be in a form ready to be administered and must not require preparation by school staff.
5. It is the parent's responsibility to deliver and maintain an adequate supply (not more than one month supply) of the medication at school. **The medication may not be delivered by the child.**
6. At the end of the year it is the parent's responsibility to pick up unused medication. Any medication left at school will be destroyed 5 working days after school is out.
7. Parents will be notified if any of the medication's side effects that are listed on the *AUTHORIZATION FOR MEDICATIONS AT SCHOOL* form or the *EMERGENCY PLAN FOR BEE STINGS AND ALLERGY/ANAPHYLAXIS* form are observed.
8. Physician's orders to administer medications are current until the end of the school year and must be renewed in writing with the start of each school year.
9. If the dosage of a medication changes, the school requires a new authorization form and a newly labeled container from the pharmacy.
10. The school expects your child to come to the office at the appointed time for their medication. Personnel can only administer medication in accordance with the physician's instructions and at the prescribed time.
11. In order for a student to receive medication at school, all procedures must be followed by parents, physicians, and the student. If these conditions are not met, the student's medication procedure will be reviewed and possibly discontinued.
12. When the student is on a field trip and medication must be administered during school hours or during such time that the student is under supervision of school personnel, the parent will need to make arrangements with the school at least 24 hours prior to the trip.

AUTHORIZATION FOR MEDICATIONS AT SCHOOL **Lynden Christian School/Evergreen Christian School**

FAX NUMBER: 360-354-6690

Student_____ Birthdate_____ School_____

Medication will be administered by trained designated school personnel to a student at school only when absolutely necessary per RCW 28A.210.260-270 and RCW 18.71.030 (3). Lynden Christian School accepts no responsibility for unanticipated reactions when the medication is administered in accordance with the directions of the student's Health Care Provider. Orders must be nondiscretionary and legible.

This form should not be used to prescribe emergency medications or injections.

Please complete a form for each medication needed while under school supervision, including activities and field trips that extend beyond regular school hours and overnight trips. ONLY ONE MEDICATION PER FORM

Section #1: To be completed by PARENT/GUARDIAN

Please check only one:

_____ I request that authorized staff administer the medication indicated in Section #2. Health Care Provider's Signature needed.

_____ I request that my child be allowed **to self-administer prescription medication** indicated in Section #2. Health Care Provider's signature needed **(grades 9-12 only, with exception of inhalers).**

_____ I request that my child be allowed to **self-administer over-the-counter medication** (RCW 26.28015 or RCW 70.02.130). **Students in grades 9-12 only.** Parent must sign below and complete medication information in Section #2. No Health Care Provider Signature is needed.

➢ **By signing this, I consent to exchange of information regarding this medication authorization between the school and the Health Care Provider. I have read and understand the information on Page 2 of this form.**

_____ _____ _____

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

Section #2 To be completed by the HEALTH CARE PROVIDER (or parent, if over-the-counter self-administered)

This medication will be: _____ **Staff Administered** _____ **Self-administered (Grades 9-12 only, except inhalers)**

Diagnosis/reason for medication_____

Name of medication_____ Dose to be given:_____

___ Oral (MDI, Nebulizer inclusive) ___ Topical ___ Eye drops ___Ear drops ___Nasal ___Rectal ___other:_____

Specific Time(s) ___:___AM ___:___PM and frequency of administration _____

_____

Possible side effects _____

Length of prescription: _____ current school year (including summer school) _____Other:_____

I request and authorize that the above-named student be administered or be allowed to self-administer the above-identified medication in accordance with the instructions indicated.

_____ _____

Licensed Health Care Provider Signature Date

_____ _____

Licensed Health Care Provider Printed Name Phone

Parent/Guardian Information and Asthma Action Plan located on back of form. OVER ➡

2/2017

PARENT/GUARDIAN INFORMATION REGARDING MEDICATIONS IN SCHOOL

I certify that I am the parent, legal guardian, or other person in legal control of this student. I request and authorize the school to administer the medication prescribed, as authorized by RCW 28.A210.260-270 and RCW 18.71.030 (3). This includes oral, inhaled, topical, nasal, rectal, eye and ear drops that shall be given at school **only when absolutely necessary**. Designated/trained employees shall administer this medication in compliance with Licensed Health Care Provider (LHCP) orders.

I understand the medication must be furnished in the **current, original container** from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and **must not** require any preparation by building staff. If the dosage or time should change, new orders and container will be provided.

I understand it is my responsibility to deliver and maintain an adequate supply of the medication at school.

I understand medication orders are only valid for the current school year (including summer school). Any medication remaining at the end of the school year, not picked up immediately after the last day of school, will be disposed, with the exception of Extended School Year students.

If self-administration is requested (and approved by principal/nurse), I certify that my child has the skill level necessary to do so, and that the school will assume no responsibility/liability for the administration of the medication or its use. Student may only carry a one day supply of oral medication.

ASTHMA ACTION PLAN

☐ **Intermittent** has symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside to these few episodes, a student is free of symptoms.

☐ **Mild** Symptoms occur more than twice a week but less than once a day, flare-ups may affect activity.

☐ **Moderate** Symptoms occur daily, flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.

☐ **Severe** Symptoms occur daily and often, also curtail the student's activities and disrupt sleep.

WARNING SIGNS OF AN ASTHMA ATTACK:	EMERGENCY RESCUE PLAN:
• Constant cough • Difficulty breathing with struggling or gasping for breath, or an audible wheeze with breathing • Stooped body posture • Trouble walking or talking, or stops playing and can't start activity again • Lips or fingernails are grey or blue (light complexion only) • _____	• Remove student from known triggers, if possible. • Accompany student to health room • Give medication as prescribed: • Keep student sitting up and reassure student • Encourage student to drink warm fluids
• No improvement 15-20 minutes after initial treatment with medication.	• Notify parent. • Call school nurse • If parents are unable to come within 10 min call 911
If student is in severe distress	**Call 911.** Notify parent, principal and school nurse.