South Washington County Schools Independent School District 833
OFFICE OF SPECIAL SERVICES
7362 E. Point Douglas Road S. Cottage Grove, MN. 55016-3025

## MEDICATION/PROCEDURE FORM (SIDE 1)

# DISTRICT PROCEDURES AND MINNESOTA GUIDELINES REQUIRE THE FOLLOWING:

1. Medications which are required during school hours and which the parent/guardian is unable to come and administer, must be administered by a nurse or a designee to whom the Licensed School Nurse has trained and delegated the function of medication administration.
2. Medication to be given at school is to be supplied in the original container/prescription bottle. A bottle of the medication should be prepared by the pharmacist, for school, with the appropriate labeling for school use.
3. Written parental permission and licensed health care provider permission are both required for all prescription medication. A new authorization form must be completed annually in the fall of the year. **PARENT/GUARDIAN(S) MUST COMMUNICATE MEDICATION NEEDS WITH KIDS CLUB, IF APPROPRIATE.**
   *Written parental permission is required for all medications (prescription or over the counter).
   NOTE: No "ASPIRIN" or Aspirin containing products will be accepted for administration to students without authorization from a licensed prescribing practitioner.
4. All medication must be accompanied by specific instructions, when and how it is to be given, and for how many days.
5. All medication must be kept in a locked cabinet and administered in the health office. Special exceptions to these circumstances may be made when approved and deemed safe by the Licensed School Nurse. Examples may be self-carry, IEP, 504, or health plan related issues.
6. **UNDER NO CIRCUMSTANCES** will school personnel provide any over the counter medication to students. Schools do NOT have stock medications.
7. All medication administered must be approved by the F.D.A., unless a licensed prescribing practitioner and a License School Nurse deems it medically necessary that it be administered during the school day.
8. Administration of each dose of medication shall be recorded on the student's electronic health record.
9. Health staff will not send prescription medication home with a student unless pre-arranged with a parent. Any medication remaining in the health office past the end of the school year will be properly disposed of.

**This form should be completed by parent/guardian and physician/licensed prescriber, if necessary. The form should be returned to the school your child attends (faxing is acceptable).**

| SCHOOL | PHONE | FAX | SCHOOL | PHONE | FAX |
|---|---|---|---|---|---|
| **Armstrong** | **425-4102** | **425-4115** | **Cottage Grove Middle** | **425-6812** | **425-6828** |
| Bailey | 425-4802 | 425-4815 | Lake Middle | 425-6412 | 425-6428 |
| **Central Park** | **425-2711** | **739-1538** | **Oltman Middle** | **425-3511** | **425-3555** |
| Cottage Grove Elem | 425-5802 | 425-5815 | Woodbury Middle | 425-4507 | 425-4567 |
| **Crestview** | **425-3802** | **425-3815** | **SWAHS** | **425-7001** | **425-7015** |
| Grey Cloud | 425-4202 | 425-4215 | East Ridge High | 425-2304 | 425-2307 |
| **Hillside** | **425-4002** | **425-4015** | **Park High** | **425-3706** | **425-3705** |
| Liberty Ridge | 425-5902 | 425-5915 | Woodbury High | 425-4403 | 425-4412 |
| **Liberty Ridge Site II** | **425-7162** | **425-7165** | **Next Step** | **425-5106** | **425-5362** |
| Middleton | 425-4902 | 425-4915 | | | |
| **Newport** | **425-4302** | **425-4315** | ****Kids Club – All Sites** | **425-6637** | **425-6620** |
| **Nuevas Fronteras** | **425-3102** | **425-3115** | | | |
| Pine Hill | 425-3902 | 425-3915 | DPC/ECSE | 425-6162 | 425-6199 |
| **Pullman** | **425-3602** | **425-3615** | | | |
| Red Rock | 425-5602 | 425-5615 | | | |
| **Royal Oaks** | **425-4702** | **425-4715** | **New Life** | **757-4330** | **459-3080** |
| Valley Crossing | 425-7502 | 425-7515 | St Ambrose | 768-3014 | 768-3080 |
| **Woodbury Elem** | **425-4602** | **425-4615** | **Hope Christian Academy** | **459-6438** | **769-2108** |

**NOTE: Medication will not be administered without proper authorization. OVER**

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# MEDICATION/PROCEDURE FORM (SIDE 2)

**Student Name:** _____ **Date of Birth:** _____

**School:** _____ **Grade:** _____ **Date:** _____

## AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION/TREATMENT

**HIPPA – Compliant Authorization for Exchange of Health and Education Information**

**Medications at School:**

***Prescription Medications –** Requires authorization from the parent and licensed health care provider.

***Non-prescription Medication (OTC) – Requires authorization from the parent**

**Procedures at School:**

***bladder catheterization *blood glucose monitoring *gastrostomy feeding *oxygen administration *blood pressure monitor on a regular basis**

**LICENSED HEALTH CARE PROVIDER AUTHORIZATION** *Medications/procedure must be medically necessary during school hours

| Diagnosis & ICD 10 | Medications/Procedure* | Dose | Time | Route | Possible Side Effects |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

**Other considerations/directions:** _____ **Start Date:** _____ **Stop Date:** _____

_____ _____ _____
PRINT NAME of Licensed Prescriber | Signature of Licensed Prescriber | Date

_____ _____ _____
Clinic Name/City | Phone Number | Fax Number

## PARENT/GUARDIAN AUTHORIZATION

- The purpose of this consent form is to authorize for the safe and necessary administration of medication and treatment in school.
- Legally, you may refuse to sign, if you refuse, we will not be able to provide service.
- Information regarding this order will only be given to South Washington County School District 833 staff who need this information to support the student's education.
- The prescribing health professional may release information to and request information from South Washington County School District related to the authorized service.
- District 833 professional staff may release information to and request information from the prescribing health professional related to the authorized service.
- A photocopy/fax of this authorization that has not been altered will be treated in the same manner as the original.
- I recognize that health records, once received by District 833, may no longer be protected by HIPPA, but they will become educational records protected by the Family Educational Rights and Privacy Act (FERPA).
- I request the above medication(s) be given during school hours as ordered by the student's physician/licensed prescriber.
- I will notify the school of any change in the medication(s). Example: dosage change, medication is stopped, etc.
- I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
- The authorization expires at the end of each school year or after summer school term.
- I understand that an individual and/or an emergency care plan may be written by the school.
- I understand that communication regarding the above health condition and/or medication with parent(s)/guardian(s) as well as the health professional may be in electronic form which could include email, SMS, etc.

**PLEASE CHECK ONE OF THE OPTIONS BELOW FOR RETURNING MEDICATION AT THE END OF THE YEAR.** Any medications left after the last day of school will be disposed of appropriately.

_____ I will pick up all medication from the health office by the end of the last day of school.
_____ Please send home all medication in my student's backpack on the last day of school.

_____ _____ _____
Parent/Guardian Signature | Relationship to Student | Date