

Integrated Day Charter School

Governing Board



Policy Series: 5000

Policy Number: 5305

ADMINISTRATIVE REGULATION 5305.1

MEDICATION ADMINISTRATION IN SCHOOL

MEDICATION WILL BE ADMINISTERED IN SCHOOL UNDER THE FOLLOWING GUIDELINES:

1. A physician, dentist, APRN, or PA feels there is a need for the medication to be administered during school hours.
2. A completed and signed authorization form from the physician, dentist, APRN, or PA is presented to the school nurse, as required by Connecticut State Law.
3. As required by Connecticut State Law, the parent/guardian will be expected to provide the appropriate completed authorizations prior to medication being administered in school.

MEDICATION MUST BE BROUGHT TO THE SCHOOL OFFICE BY THE PARENT, GUARDIAN, OR ASSIGNED ADULT. MEDICATION MUST BE SUPPLIED IN A PHYSICIAN, DENTIST, OR PHARMACY PREPARED AND LABELED CONTAINER.

NON-PRESCRIPTION MEDICATION ORDERED BY A PHYSICIAN, DENTIST, APRN, OR PA MUST BE SUPPLIED BY THE PARENT/GUARDIAN WITH A COMPLETED AUTHORIZATION IN AN ORIGINAL PREPARED AND LABELED CONTAINER.

MEDICATION IS NOT TO EXCEED A FORTY-FIVE (45) SCHOOL DAY SUPPLY!!!

All medication when discontinued must be picked up by the parent, guardian, or assigned adult within one week. Medication not picked up within the designated time will be discarded according to Connecticut State Regulations.

If you have any questions, please phone your child's school nurse.

THANK YOU FOR YOUR COOPERATION.

**INTEGRATED DAY CHARTER SCHOOL
Health Form**

Authorization for the Administration of Medication by School Personnel

The Connecticut State Law and Regulations require a physician/dentist/APRN/PA's written order and the parent and/or guardian's authorization for a nurse to administer medications or, in the absence, the director and/or teacher to administer medications. Medications must be in pharmacy-prepared containers and labeled with the name of the student, name of the drug, strength, dosage, frequency, physician's and/or dentist's name, and date of original prescription.

PHYSICIAN/DENTIST/APRN/PA ORDER

Name of student _____ Date _____

Address _____ Date of birth _____

Condition to which drug is being administered during school hours _____

Drug (name, dose and method of administration) _____

Type of Administration _____

Medication shall be administered from _____ to _____
Date Date

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Physician/Dentist name _____ Telephone _____
(type or print)

Address _____

Physician/Dentist Signature _____ Date _____

Nurse will consult with physician/dentist/APRN/PA as needed.

Authorization by parent/guardian for the administration of the above medication by school personnel:

Date _____

To School personnel"

I hereby request that the above medication, ordered by the physician/dentist/APRN/PA for my child, _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispersed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication. I understand that this medication will be destroyed if it is not picked up one week following the termination of the order or one week beyond the close of school.

Name _____ Relationship to student _____

Signature _____

Address _____ Telephone # _____

MEDICATION ERROR OR INCIDENT REPORT

Date of Report ____/____/____

Prepared by: _____

Student's Name _____ Grade _____

Home Address _____

Phone _____

Date Error Made ____/____/____

Time Noted _____ a.m/p.m.

Person Administering Medication _____

Prescribed by: _____ Date of Order ____/____/____

Reason Medication was Prepared _____

Instructions for Administration _____

Medication	Dose	Route	Scheduled Time	Dispensing Pharmacy	Prescription #

Describe the error and how it occurred (use reverse side if necessary)

Action Taken:

Was prescribing practitioner notified? _____

Record date ____/____/____ Time _____ and comments of practitioner _____

Was parent/guardian notified?

Record date ____/____/____ Time _____ and comments of parent _____

Outcome:

Name _____

Print or type

Signature

Time/Date

Forwarded completed copy of form to Director's Office.

VERBAL OR TELEPHONE MEDICATION ORDERS

Student's Name : _____ Date: ____/____/____

Grade _____ Teacher _____

Physician's Name: _____ Phone # _____

Medication Prescription:

Dosage: _____

Method of Administration: _____

Strength: _____

Frequency: _____

Date(s) to be Administered: From ____/____/____ To ____/____/____

School Nurse's Signature

Date

Date Sent to Physician: ____/____/____

Date Received: ____/____/____

Verbal or Telephone Orders not signed and received by the school nurse within three (3) school days will be discontinued. Parents will be notified.

REFERRAL FOR EYE EXAMINATION

Student's Name: _____ Age: _____ Grade _____
Parent/Guardian: _____
Address _____
From: Nurse _____ School _____

Vision screenings have recently been administered to students at IDCS. On the basis of these screening results, we are recommending that _____ have a thorough eye examination. Therefore, we suggest that you take him/her to an eye specialist (oculist, ophthalmologist, optometrist) for further examination or that you follow the recommendation of your family physician.

Date of test: ____/____/____ Test Used: _____

Results of test: _____

REPORT OF EYE EXAMINATION

Visual Acuity: Without correction With best correction with ordinary lenses Without correction With best correction with ordinary lenses

Right Eye (OD) _____

Left Eye (OS) _____

Both Eyes (OU) _____

If glasses are to be worn, were safety glasses prescribed in: Plastic _____ Tempered glass _____

PROGNOSIS AND RECOMMENDATIONS

1. Student's vision impairment is considered: Stable _____ Deteriorating _____
Capable of Improvement _____ Uncertain _____

2. What treatment is advised?

3. Re-examination advised: _____ At what interval: _____

4. Glasses not needed: _____

5. Lighting requirements: Average: _____ More than average: _____ Less than average: _____

6. Use of eyes: Unlimited: _____ Limited as follows: _____

7. Physical Activity: Unrestricted: _____ Restricted as follows: _____

8. Other recommendations: _____

Return to School: _____ Date of Examination: ____/____/____

Signature of Examiner _____

Address _____ Phone _____

REFERRAL OF STUDENT TO PHYSICIAN FOR HEARING EVALUATION

Student's Name: _____ Date: ____/____/____
School/Grade: _____ Date of Birth: ____/____/____
Parent/Guardian: _____
Address: _____

Name of Person Making Referral: _____
Address: _____

This student was referred because of failing:

- A. _____ Pure-tone hearing screening on ____/____/____
- B. _____ Impedance (Acoustic Admittance) screening on ____/____/____
- C. _____ Both pure-tone and impedance screening on ____/____/____

PHYSICIAN'S REPORT OF EVALUATION

Student: _____ Date of Evaluation: ____/____/____
The above named student: _____ has a loss in ____ left, _____ right ear
_____ has no loss

Findings:

Diagnosis:

Recommendations: _____ Speech Evaluation _____ Selective Seating _____ Other

Signature of Evaluating Physician: _____

Address & Phone: _____

AUTHORIZATION FOR TREATMENT

Physician Order

Student Name: _____ Date: ____/____/____
Address: _____ Date of Birth: ____/____/____
School: _____ Grade: _____

Condition for which treatment is ordered

Treatment ordered

Observations

Duration of Treatment: From ____/____/____ To ____/____/____
Date Date

Physician Signature _____, M.D.

Address _____

Phone _____

School nurse will consult with physician as needed.

PARENT/GUARDIAN AUTHORIZATION

I request that _____ be given the above ordered treatment.

Name of Student

Signature _____

Parent/Guardian

Address _____

Phone _____

