LATHROP R-II SCHOOL DISTRICT
HEALTH SERVICES

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Lathrop Middle/High School Nurse

Physician Authorization for Medication to be taken at School

The School Health Room requires a physician's order current for **each school year** for ALL prescription items to be used in school, OR any over the counter items which need to be administered in different dosages or for different reasons than listed on the bottle. (Any over the counter medication may be given according to container instructions, as long as the medicine is accompanied with a written parental permission.)

PHYSICIAN SECTION:

Student Name: ____________________________ Date of Birth: __________School Year: __________

Diagnosis for which medication is given: ____

Name of Medication: ____

Dosage: ______________________ Route: ______________ Frequency: _________________________

If medication is scheduled, please specify time ____

If medication to be given "WHEN NEEDED". Describe indications: __________________________________

List significant side effects: ____

Duration: ____

(If none specified, Authorization will expire at end of current school year)

Grades 6-12 only: Student is authorized to carry and **self-administer** this medication as it is considered a **life-saving** medication.

_______YES _________ NO

(*If yes, please fill out reverse side of form*)

Physician signature: ____Date: _____________________

PARENT/GUARDIAN Section:

Parent/Guardian Name: __________________________________ Relationship to Student: ________________

- I request this medication to be given by the Health Room Staff of Lathrop School District. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- I give Health Services Staff permission to communicate with the medical office about this medication.
- Medication information may be shared with school staff working with my child and Emergency services if needed.
- All medication supplied must be brought to school in its original container with prescription details as noted above by the licensed health professional.

Parent/Guardian Signature ____ Date _________________________

Revised 4/2016

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LIFE-SAVING MEDICATION SELF-ADMINISTRATION FORM

Student Name: ________________________________ Birth-date: ___________ Grade: _____ School Year: _____

The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer life-saving medications when the following criteria are met:

1. *A licensed physician prescribed or ordered the medication for use by the child and instructed such child in the correct and responsible use for the medication –follow the school's medication policy/guidelines.*
2. *The child's physician has approved and signed a written treatment plan for managing asthma or anaphylaxis episodes of the child and for the medication for used by the child. Such plan shall include a statement that the child is capable of self-administering the medication under the treatment plan*
3. *The child has demonstrated to the child's physician or licensed physician's designee the skill level necessary to use the medication and any device necessary to administer such medication prescribed/ordered.*
4. *Parent/guardian has completed and submitted to the school any written documentation required by the district (including but not limited to the treatment plan/liability-permission form).*

Emergency Medication: - Please check medication or fill out medication as prescribed.

- ☐ Albuterol inhaler ________dosage– 2 puffs inhaled every 4-6 hours as needed for cough/wheezing/chest tightness
- ☐ Albuterol inhaler ________dosage – 2 puffs inhaled 15-20 minutes before exercise if needed
- ☐ Epinephrine ___________ dosage-1 intramuscular injection as needed for symptoms of severe allergic/anaphylactic reaction.
- ☐ Insulin _________type __________dosage- 1 subcutaneous injection as needed for severe symptoms hypoglycemia or via controlled continuous pump. (MUST BE ACCOMPANIED BY DIABETIC MANAGEMENT PLAN)
- ☐ Other: ____

ALL EMERGENCY MEDICATIONS MUST BE ACCOMPANIED BY A PHYSICIAN-SIGNED ACTION PLAN

PHYSICIAN STATEMENT FOR STUDENT TO SELF -ADMINISTER:

I, certify that the above named student has a medical history of asthma, acute bronchitis, or other ________________, health condition requiring this student to carry the specified medication. The student has been instructed in the proper self-administration of the medication(s) listed above and is judged to be capable of carrying and self -administering the listed medication(s). The student understands he/she should notify school staff if they continue to have symptoms. The student has been instructed and understands the hazards of sharing medication with others and has agreed to refrain from this practice.

Physician Signature: ____ Date: ________________

Physician Name: ____ Phone number: ________________

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF -ADMINSTER:

I, the parent/guardian of the above named student given permission for the student to carry and self-administer the above listed medication(s). I have instructed my child to notify school staff if he/she continues to have symptoms. My child understands his/her symptoms and when to use the specified medication. I understand and have provided my child with medication in the original container with attached prescription label at all times. My child understands the hazards or sharing medication with others and has agreed to refrain from this practice. I understand the district's medication policy/guidelines. It is my responsibility to provide the health room with a back-up inhaler. I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration.

Parent Signature: ____ Date: ___________________

STUDENT UNDERSTANDING STATEMENT: I understand my diagnosis. I have been instructed on the proper timing and use of my medication. I understand that if I do not have relief of my symptoms to tell a staff member. I know that under NO circumstances to share medication with another person. I understand I must have the prescription label attached to the original medication container at all times.

Student Signature: ____ Date: ____________________

****Please Note**: If the student is found to be out of compliance with the above criteria after passing initial observation, this privilege may be revoked pending a review and reassessment by the school nurse or school administrator.