

Solon City Schools Medication Procedure

The Solon Board of Education has a policy dealing with the dispensing of all medication. The medication policy is available upon request. Medication at school can often mean that a child who has a chronic disability or illness can attend class. To prevent any unforeseen and/or unfortunate circumstances, parents are required to follow the procedures in the policy. Whenever possible, medication should be dispensed at home and not at school.

PRESCRIPTION & NON-PRESCRIPTION MEDICATION PROCEDURE

1. **A statement signed by the physician that prescribes the medication** for the student must accompany the medication. The statement must include the following:
 - a) Name and address of the child
 - b) Drug name, dosage, times or intervals it is to be administered
 - c) Date administration of the drug is to begin and cease
 - d) Special instructions for administration and storage of drug
 - e) Any severe adverse reactions that should be reported to the physician and a phone number at which the physician can be reached in an emergency.
2. **Written permission from the parent/guardian** of the student requesting that the school district comply with the physician's order must accompany the medication.
3. **Medication must be received in the original container** in which it was dispensed. Containers must be clearly labeled with student's name, medication, dosage, and prescribing physician's name. It is recommended that only the amount of medication that will be dispensed in school be sent to school. Parents are requested to bring the medication and forms to school. A medication form is available upon request for the school nurse or office.

If the above policy is not followed, the student WILL NOT be given the medication.



Physician's Request for Administration of Medication by School Personnel

Patient's Name: _____ Name of Medication: _____

Administration of this drug should begin on _____ and cease on _____

Dosage: _____ at the following times or intervals: _____

Special Instructions (i.e. sterile conditions and storage): _____

Severe side effects that should be reported to me: _____

Physician's Signature

Physician's Name (please print)

Phone Number

Date

Address

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Parent's Request for Administration of Medication by School Personnel

I hereby request and give permission to the principal, school nurse, health aide, or other designee to administer the above noted medication to my child. I agree to submit a revised statement, signed by the prescribing physician, when any of the above information changes. Furthermore, I agree that no employee who is authorized by the Solon Board of Education to administer a prescribed drug and who has a copy of the most recent physician's statement would be liable in civil damages for administering or failing to administer the drug, unless he/she acted in a manner that would constitute gross negligence or wanton or reckless misconduct.

Child's Name

School

Child's Address

Teacher and Grade

Home Phone

Work Phone

Emergency Phone

Parent or Guardian Signature

Date

