SHORELINE
CHRISTIAN SCHOOL

MEDICATION ADMINISTRATION POLICY

Purpose: to provide for the safe administration of prescription and non-prescription medications to students.

Prescription Medications, Administered by the school staff – Oral, inhaled or injectable

(Available to students in grades K-12)

I. If it is necessary for a student to receive oral or inhaled medication which is deemed necessary to be administered by the school during school hours, the medication must be:
   a. provided in the clearly labeled, unexpired, original container
   b. accompanied by the completed SCS Authorization for Prescription Medications to be Taken at School form which is signed by the physician/nurse practitioner/ physician's assistant/ dentist/ parent (faxed forms are allowed)
   c. administered by and logged by an employee designated by the Administrator
   d. stored in a locked area not accessible to students

II. Injectable Medications – Under normal conditions, no injectable medications are kept on campus. Any conditions requiring administration of injectable medications must be reported to the school during the registration process or as soon as the condition becomes known, so that individual arrangements can be made.

III. Medication will be administered until one of these situations occurs:
   a. the medication supply is used up
   b. the prescription expires (if a prescription medication)
   c. the school year ends
   d. the parent makes a written request that the medication be stopped

IV. It is the student's responsibility to report to the office at the set time to receive medication.

V. Failure to follow the stated policy will result in the medication not being administered.

Non-Prescription Medications, Self-Administered by the student – Oral or inhaled

Available to students in grades 7-12.
(Grades K-6 must keep all medicines including non-prescription in the office for dispensing.)

I. If it is necessary for a student to receive oral or inhaled medications during school hours which the parent deems may be self-administered (non-prescription):
   a. the administration of the medication becomes the sole responsibility of the student
   b. a completed SCS Authorization for Self Administration of Non-Prescription Medication form which is signed by the parent or guardian must be provided to the office prior to the self-administration of the medication.
   c. the medication must be retained by the student for the exclusive use of the student.

II. Failure to follow the stated policy may result in disciplinary action.

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AUTHORIZATION FOR PRESCRIPTION MEDICATIONS TO BE TAKEN AT SCHOOL

Student's Name _____ Birth date _____Grade_____
Last First

The following section is to be completed by the HEALTH CARE PROVIDER

Name of Medicine:_____ Dose:_____

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Diagnosis for which medication is given: _____

If medicine is to be given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

_____

How soon can it be repeated? _____

Is child authorized to medicate himself/herself? ☐ yes ☐ no

List significant side effects: _____

_____

Length of time this treatment is recommended: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with _____and ending with _____ as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Health Care Provider's Signature: _____ Date: _____

_____
Health Care Provider's Name (Print or Type) Address Phone

To be completed by the Parent or guardian:

I certify that I am the parent, legal guardian or other person in legal control of the above identified student, I have read the Medication Administration Policy of Shoreline Christian School and I request and authorize the school personnel (medically untrained) to administer the above identified medication to the above identified student in accordance with the prescription or doctor/dentist/professionals' instructions for the period beginning _____ and ending _____, not to exceed one school year. I am supplying the medication to the school in the original, unexpired container.

_____
Parent/Guardian Signature Date Home Phone Emergency Phone

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Authorization for Administration of Non-Prescription Medication for Grades K - 6

Student's Name_____ Grade _____ Birth date _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Medication*	Dosage Administered	Frequency	Method of Administration	Reason for Administration

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. **I am supplying the medication for my student.**

Further, I certify that I have read and understand the Medication Administration Policy of Shoreline Christian School. See attached.

Parent/Guardian Name _____ _____ _____
Print Signature Date (valid for one year)

Phone Number (H)_____ (C)_____ (W)_____

*** Please bring the medication in its original container with your student's name on it into the office.**

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Authorization for Self Administration of Non-Prescription Medication
for Grades 7-12

Student's Name_____ Grade _____ Birth date _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Medication	Dosage Administered	Frequency	Method of Administration	Reason for Administration

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request that the above named student be allowed to self-administer the medication listed above. **I am supplying the medication for my student in an original container with students name clearly marked on it.**

Further, I certify that I have read and understand the Medication Administration Policy of Shoreline Christian School. See attached.

Parent/Guardian Name _____ _____ _____
Print Signature Date (valid for one year)

Phone Number (H)_____ (C)_____ (W)_____