Medication Administration

Midway ISD **does not** purchase medication for students. When medication is brought to the school from home, it is desirable that the initial daily dose of medication be administered by the parent/guardian at home. Subsequent doses of medication may be administered by the school nurse, nurse assistant, or designated trained personnel, provided the following requirements are met by the parent or legal guardian.

1. All prescription and/or non-prescription medications that need to be given at school for 10 consecutive days or less require:
   - Student's Name
   - Name of medication
   - Amount (Dose) of medication to be given at school & frequency of administration
   - Reason medication is administered
   - Date(s) to be given
   - Signature of parent/legal guardian
2. All prescription and/or non-prescription medications that need to be given at school for more than 10 consecutive days require the same information as above, in addition to a physician's signature.
3. Prescription medication must be in the original container and be labeled by the pharmacist. All non-prescription medication must also be in the original container.

All medication administered at school, prescription or non-prescription, must be accompanied by the Midway ISD's Medication Administration Request form. This form can be found on Midway's website, http://www.midwayisd.org, under the parent tab on the main page.

All medications must be stored in a locked cabinet in the school clinic. Requests for exceptions must:

- Be limited to medications for severe life threatening symptoms
- Be approved by the principal or school nurse
- Be accompanied by a written request from the prescribing physician and parent/legal guardian
- Have an appropriate plan for the life threatening situation for which it is prescribed completed and approved by the school nurse

If at all possible, medication should be administered at home. Should a question arise regarding medications or any issue, the school nurse may call the physician, pharmacist, and/or the parent/legal guardian for clarification. **In accordance with the Nurse Practice Act, Texas Administrative Code 217.11, the school nurse has the responsibility and authority to refuse to administer medications that in the nurse's judgment are not in the best interest of the student. In accordance, herbal medications will not be administered by the school nurse or school personnel.**

Medications prescribed to be given three times a day or less **will not** be given at school unless a specific time during the school hours is prescribed by the physician, or the school nurse determines that a special need exists for an individual student.

Only medication prescribed by a physician licensed to practice medicine in the United States is acceptable for school use. Medications from other countries **will not** be administered by school personnel.

Only **one medication** per properly labeled container is allowed.

A dosage change requires a new medication order from the parent/guardian and prescribing physician.

Requests for administration of medication expire at the end of the school year. Any medication not picked up by the last day of school will be discarded by the nursing staff.

MEDICATION ADMINISTRATION REQUEST
For Asthma Medications including Asthma Action Plan

DATE________________

NAME OF STUDENT____

CONDITION BEING TREATED____

NAME OF MEDICATION____

DOSAGE AND ROUTE OF MEDICATION_________________________________

TIME OF ADMINISTRATION OF DRUG AT SCHOOL_____________________

SPECIAL INSTRUCTIONS OR POSSIBLE REACTIONS___________________
____
MEDICATIONS GIVEN AT SCHOOL MAY BE ADMINISTERED BY A MEDICALLY UNTRAINED DESIGNATE OF THE SCHOOL OR THE SCHOOL NURSE.

______________________________ ______________________________
PHYSICIAN'S NAME (PRINT) **PHYSICIAN'S SIGNATURE**
PHYSICIAN'S TELEPHONE NUMBER________________________________

I GIVE MY PERMISSION TO SCHOOL STAFF TO ADMINISTER THE MEDICATION AS PRESCRIBED ABOVE.
PARENT/GUARDIAN SIGNATURE____
DAYTIME PHONE NUMBER____

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS:
I HAVE INSTRUCTED THE STUDENT IN THE PROPER WAY TO USE HIS/HER ASTHMA MEDICATION. IT IS MY PROFESSIONAL OPINION THAT HE/SHE SHOULD BE ALLOWED TO CARRY AND/OR SELF-ADMINISTER THE MEDICATION WHILE ON SCHOOL PROPERTY OR AT SCHOOL RELATED EVENTS.

PHYSICIAN'S SIGNATURE____

I AGREE THAT THE ABOVE NAMED STUDENT IS PROPERLY TRAINED IN THE USE OF HIS/HER ASTHMA MEDICATION AND REQUEST THAT THE STUDENT BE ALLOWED TO CARRY AND/OR SELF-ADMINISTER THE MEDICATION WHILE ON SCHOOL PROPERTY OR AT SCHOOL-RELATED EVENTS.

PARENT SIGNATURE____

*****IF ANY OF THE ABOVE NAMED MEDICATIONS ARE TO TREAT OR PREVENT ASTHMA, THE EMERGENCY PLAN ON THE REVERSE SIDE MUST BE COMPLETED BY A PHYSICIAN.**

This plan is in accordance with new legislation, HB 1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from parents and physicians.

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal.)

DAILY TREATMENT PLAN
Please list any medications taken daily to manage asthma, including nebulizer treatments.

NAME	PURPOSE	DOSAGE	WHEN TO USE
______________________________		____________	__________________
______________________________		____________	__________________
______________________________		____________	__________________

These medications are prescribed for the time period_________________ until ___________________.

Medical Equipment:
Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.).
____

*****************************EMERGENCY PLAN***********************************

Emergency action is necessary when this student has symptoms such as:
1.______________________________ 3.____________________________
2.______________________________ 4.____________________________

Steps to take during an asthma episode:
Give emergency medications:
A. Bronchodilator (Quick-relief medication):
Name: ____
Purpose: ____
Dosage: _______________________When to use: ______________________
Can be repeated for severe breathing difficulty_____times____minutes apart.
CALL 911 OR EMS IF MINIMAL OR NO IMPROVEMENT
B. Other medications:
Name: ____
Purpose: ____
Dosage: ______________When to use: _______________________________
Additional Instructions: ____
These medications are prescribed for the time period___________________until________________.

Seek emergency medical care if this student experiences any of the following:
*No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
*Student exhibits:
-chest and neck pulled in with breathing
-stops playing and cannot start activity again
-trouble walking or talking
-struggling to breathe
-hunched over while breathing
-lips or fingernails turn gray/blue

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PHYSICIAN'S SIGNATURE: ____

SPECIAL INSTRUCTIONS: ____