

**MEDICATION ORDER TO CARRY
PRESCRIBED/ OVER THE COUNTER MEDICATION**

**INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT
TO CARRY PRESCRIBED / OVER THE COUNTER MEDICATION**

For online forms: <http://sbo.nn.k12.va.us/healthservices/medications.html>

These requests are exceptions to School Board policy JLCD and must be approved.

1. *Parents will submit the following forms:*
 - a. **Request for Approval for Students to Carry Prescribed Medication**
(completed by parent)
 - b. **Responsibilities of Student and Parent Requesting Exception to Category BSC and BESO in the Rights and Responsibilities Handbook**
(Category BSC: Behaviors that Present a Safety Concern and Category BESO: Behaviors that Endanger Self or Others.)
 - c. **Medication Release of Liability form**
 - d. **Medication Order** (signed by the medical provider and must indicate the student needs to carry at all times)

All forms must be in order and signed.

2. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*
3. *The school nurse will complete an Emergency Care Health Plan as appropriate.*
4. *The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.*
5. *The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.*
6. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*
7. *The parents will sign a form assuming full responsibility and releasing the school of liability.*
8. *The school's registered nurse and principal will sign approving the request.*
9. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*



Health Services

12465 Warwick Boulevard, Newport News, VA 23606-3041 ■ phone: 757-591-4646 ■ fax: 757-595-2017

**REQUEST FOR APPROVAL FOR STUDENT TO CARRY
PRESCRIBED/ OVER THE COUNTER MEDICATION**

(This form is to be completed by the parent. The medical provider must complete the appropriate medication order. (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies, or other medications)

For online forms: <http://sbo.nn.k12.va.us/healthservices/medications.html>

Name of Student: _____ Birth date: _____

Home Address: _____

Name of Parent(s): _____

Medication to be carried: _____

Reason student needs to carry: _____

Additional information: _____

*I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. **A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry this medication and understands how to use it.** I understand this request is for the current school year only.*

Parent's Signature

Date

Attached and completed: (All must be reviewed by RN)

___ Signed order from Medical Provider that student is trained and able to carry

___ Parent signature to request

___ Exception to Categories BSC and BESO (parent and student signed)

___ Medical Release of Liability

Notes: _____

Approved for current school year:

_____, RN
School Nurse

Date

Principal

Date



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RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO CATEGORY BSC (Over the counter medications) AND CATEGORY BESO (Prescription medications)

(Request to Carry Prescribed/Over the Counter Medication on One's Person)

I request my son/daughter _____ carry the following prescribed medication: _____.

I have read Category BSC and Category BESO which state:

***Category BSC:** Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia*

***Category BESO:** Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will result in student discipline equal to those violations of Levels 3-5, including a short-term removal from school to long-term suspension or expulsion.

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed _____ (Parent) Date: _____

Signed _____ (Student) Date: _____

MEDICATION RELEASE OF LIABILITY FORM

Student: _____ School: _____ Grade: _____

Address: _____

Parent/Guardian: _____ Phone: # _____
(Home)

_____ Phone: # _____
(Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of _____

I hereby request and authorize you to assist and/or give

(Dose and Medication)

to: _____, as prescribed by
(Student's Name)

_____. I release school personnel from liability
(Medical Provider's Name)

should reactions result from this medication, whether self-administered by my child or given by
school personnel. If possible, I prefer follow-up care and transportation as follows:

Parent/Guardian Signature

Date



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MEDICATION ORDER

It is best for students to take medication at home. When this is not possible, Newport News Public Schools will cooperate in the administration of medication during school hours.

Orders are required for all prescription and over the counter medications, supplements and herbal remedies. The asthma action plan is on the reverse of this form.

1. Medication orders are valid for the **current school year** in which they are written. New orders are required each school year. Daily medication orders must include a specific time ("lunchtime" is not acceptable as lunch varies from 10:00 a.m.-1:00 p.m.). Provider and parent signatures are required.
2. Prescription medications must be brought to school by the parent or guardian in the container labeled by the pharmacy. Over the counter medications such as Tylenol, Motrin, etc. must be received in the original, unopened container. Expired drugs will not be given. Any medication remaining on the last day of school must be picked up by a parent or it will be disposed of.

Student Name: _____ Birthdate: _____

Diagnosis: _____

Date of Order: _____

Medication: _____

Dosage: _____ Time: ☐ Daily @ _____ OR ☐ PRN every _____ hours

Effective Dates: ☐ Current School Year OR ☐ Short Term - From _____ To _____

Duration cannot exceed current school year.

Comments: _____

_____ Student needs to carry this medication on his/her person at all times, has been trained by medical provider on how to use, and understands when to seek assistance.

Medical Provider's Signature: _____

Print: _____ Phone Number: _____

I request that the school give the above medication as ordered by the provider. I give permission for the school nurse to contact the medical provider if indicated to carry out this order.

Parent/Guardian Signature

School Student Attends