-Received Meds: _____

2024-25

Authorization to Administer
OVER THE COUNTER MEDICATIONS

Student _____ Grade _____

Medication 1	**Dosage**	**Reason**	**Number of Days**
Instructions			
Possible Side Effects:			
Medication 2	**Dosage**	**Reason**	**Number of Days**
Instructions			
Possible Side Effects:			

The above medication is to be administered during the school day in accordance with above instructions. I agree to accept communication about the student and/or medication and understand the non-medical, trained school personnel may administer the medication.

School office staff, designated teachers, or school principal will administer medication. I agree to hold St. Charles School/Parish, it employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

Parent Signature _____ Date _____

PRESCRIPTION MEDICATIONS
2024-25

Student _____ Grade _____

Medication 1	**Dosage**	**Reason**	**Number of Days**
Instructions			
Possible Side Effects:			
Medication 2	**Dosage**	**Reason**	**Number of Days**
Instructions			
Possible Side Effects:			

The above medication is to be administered during the school day in accordance with above instructions. I agree to accept communication about the student and/or medication and understand the non-medical, trained school personnel may administer the medication.

School office staff, designated teachers, or school principal will administer medication. I agree to hold St. Charles School/Parish, it employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

Parent Signature _____ Date _____

2024-25

Authorization to Administer Prescription

Epi-Pen, Inhaler, Glucagon

STUDENT _____ Grade _____

Completion by Physician

Medication 1	Dosage	Indication	Expiration
Instructions			
Possible Side Effects:			
Medication 2	Dosage	Indication	Expiration
Instructions			
Possible Side Effects:			

The above medication is to be administered during the school day in accordance with above instructions. I agree to accept communication about the student and/or medication and understand the non-medical, trained school personnel may administer the medication.

Asthma Inhaler / EpiPen / Glucagon:

It is my professional opinion that the student named above carry or self-administer the above prescribed

☐ **Inhaler** and/or ☐ **EpiPen** and/or ☐ **Glucagon**

☐ **MAY**

☐ **MAY NOT**

He/she has been instructed in and understands the purpose and appropriate use of the medication.

Physician Signature: _____ **Date:** _____

Please Print: Physician Name: _____

Address: _____

Phone: _____

2024-25

Guidelines

Self-Carry & Administer

Inhaler / Epi-pen / Glucagon

Self-Administration of Medications—Asthma Inhalers, Epinephrine Auto-Injectors and Glucagon

1. By requesting that the student carry and self-administer medications, the parent/guardian must understand that school personnel will not be supervising, monitoring nor documenting the use of these medications and will not be held responsible for the safeguarding of these medications.
2. The medication must be appropriately labeled with the student's name and directions for use.
3. St. Charles emphasizes the student's responsibility to immediately report asthma symptoms not relieved by the medication, adverse reactions, or any other concern to the school health office. The Emergency Action Plan will be activated.
4. St. Charles emphasizes the student's responsibility to immediately report exposure to an allergen, symptoms of an allergic reaction and the use of the EpiPen to a school employee as the Emergency Action Plan will be activated and EMS will be called. The self-administration of epinephrine is intended to expedite the emergency response process.
5. The student/parent is responsible for ensuring the availability of their prescribed medication at all school-sponsored field trips or activities.
6. Self-administration privileges may be withdrawn if the student exhibits behavior that indicates lack of responsibility toward self or others in regards to his or her medication. Likewise, if a student allows another student to handle the self-carry medications, the privileges may be revoked. Students are NOT allowed to carry any other medications on their person or in their lockers.
7. The parent and student will communicate to the teacher and staff that the child will be providing their own inhaler and using it as trained to do so by the healthcare provider.

Procedure for Field Trips

School personnel and parents shall determine which medications will be sent on a school-sponsored field trip, and the parents will communicate in writing on the field trip consent form the medication(s) necessary for that child, including any of the following:

- Scheduled medications to be administered during the time of the field trip
- Emergency medications (i.e. Epinephrine auto-injectors, diabetic supplies and medications)
- "As-needed" medications that are specifically prescribed by a physician (inhalers, migraine medications, etc.)
- Over-the-counter medications that are used as part of an individual's Emergency Action Plan (i.e. diphenhydramine or Benadryl)

2024-25

Authorization to Self Administer Prescription

Epi-Pen, Inhaler, Glucagon

Parent Consent

STUDENT (Print)_____ DATE_____

As parent of the above-named student, I give permission for school staff to supervise the administration of the medication authorized by my physician. I agree to notify the school directly at the termination of this request or when any changes in the order are necessary. I authorize school personnel to contact the physician directly for clarification of this medical order or to report any adverse reactions/side effects. I understand that it may be necessary to share the information on this form with other school staff to ensure proper administration of this medication.

This information may also be shared with emergency medical staff in the event of a health/safety emergency necessitating transport to a medical facility.

☐ **Glucagon**: I hereby request that my child carry and/or self-administer the above prescribed as able.

☐ **Asthma Inhalers and EpiPen only**: I hereby request that my child carry and self-administer the above prescribed.

☐ **INHALER and/or** ☐ **EpiPen**: I have read and discussed the Guidelines for self-administration (see p.2) with my child and deem this responsibility appropriate for him/her.

Parent/Guardian Name (PRINT): _____

Signature: _____

Date: _____

Daytime phone number: _____

Received Meds: (Staff Initial) _____ **Date** _____