Monongalia County Schools-School Health
200 West Park Avenue
Westover, WV 26501
Phone: (304) 291-9288 Ext. 1705
Fax: (304) 292-9242

Student Name: _____ **School:** _____ **Grade**_____

Emergency Medication: _____

Reason for Medication: _____

Dear Parent or Guardian:

In an effort to be proactive in the area of student and school safety, Monongalia County Schools is offering all middle and high school students who are prescribed emergency medications at school (epi-pens, inhalers, insulin etc.) to carry those medications and supplies with them. In order for students to be allowed to self-carry their emergency medications ***the Monongalia County Schools Medication Policy requirements need to be met and the physician's order needs to reflect the student may self-carry and administer their emergency medication.***

It is suggested that diabetic students keep their diabetic supplies (glucometer, insulin pens, glucagon, glucose tablets, etc.) with them during the school day as they travel from class to class.

This provision is being put in place for situations such as a "lock down." During such events students and staff are contained to their current classroom and staff and students remain there until the lock down is over. By your student having their emergency medications/supplies with them it ensures their medical needs will not go untreated by such an event.

_____ **Yes, I agree that my child, will be responsible for carrying his/her emergency medication and/or supplies (with physician and school nurse permission) from class to class while at school.**

_____ **No, I DO NOT want my child, to carry his/her emergency medications and/or supplies. Even if my child's physician's orders state that she/he may self-carry I DO NOT wish my child to carry his/her emergency medications or supplies.**

Parent Name: _____ Parent Signature: _____ Date:_____

Student Name: _____ Student Signature: _____ Date: _____

School_____

Monongalia County Schools Medication Form

☐ HOA ☐ Care Plan

Student Information

Student Name _____
Last First Middle

Birth Date _____ Age _____ Homeroom Teacher _____ Grade _____

Medication Allergies_____

Parent/Guardian Name (Print) _____

Parent/Guardian Phone (Home) _____ (Work) _____ (Cell) _____

Physician

<u>This section of the Medication Form is to be filled out by a licensed prescriber.</u> Medication orders are valid for the current school year including any summer school programs or extended school year programs. A medication order is required for <u>any prescription and non-prescription (over the counter) medication.</u> If there is any change in medication, dosage, time, or route, a new medication order must be received <u>before</u> the medication can be administered by school personnel. By signing this form, the licensed prescriber is authorizing that this medication may be given at school.

Prescribed and Non-Prescribed Medication
(Use one form for each medication)

Medication _____ Diagnosis/ICD-9 Code _____

Dose _____ Time _____ Route _____

Intended Effect of Medication _____

Potentially Serious Side Effects for this Medication _____

If rectal Diastat/Diazepam or Klonopin are prescribed, may this be administered by unlicensed, trained personnel?
___Yes ___No

May the student self-administer their emergency medication per county policy? ___Yes ___No

May the student carry their emergency medications on him/her per county policy? ___Yes ___No

Name and Title of Licensed Prescriber (PRINT) _____

Address _____

Phone _____ Fax_____

Signature of License Prescriber _____ Date _____

Parent/Guardian

Parent/Guardian Authorization

The first dose of this prescribed medication has been given at home? ___ Yes ___ No **Parent Initial** _____

I understand that the medication must be in the original container and properly labeled bearing the child's name.

I understand the licensed prescriber may be contacted concerning the medication order for reasons including, but not limited to, clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.

I understand that, with due notification of licensed prescriber and parent/guardian, the school nurse/Monongalia County Schools may discontinue medication administration if student's health appears to be at risk.

I understand that medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.

I understand a photograph of my child may be taken to assist in the correct administration of my child's medication.

I hereby give permission for my child to receive medication at school per the Monongalia County Schools Medication Policy and as ordered by my child's licensed prescriber.

Parent/Guardian Signature_____ **Date**_____