ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

OVER THE COUNTER PRESCRIBER AUTHORIZATION

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

PHYSICIAN ORDER REQUIRED by LEA : YES ____ **NO**____

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No _

Is self- medication permitted and recommended? Yes ☐ No _

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No _

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( )_____-_____ **Fax:** ____-____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( )_____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: **Date:** / / **Phone:** ( ) -

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Emergency Drug required during Bus Transportation Yes ☐ No ☐

Cake Icing Gel ONLY for Diabetic Student during Bus Transportation Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( ) _____-_____ **Fax:** _____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone:** ( ) _____-_____

Revised 06/2017

(Local Education Agency)

Medication Self-Administration Documentation and/or Medication Authorized to Keep On Person Documentation

Student Name_____ Grade _____

Name of Medication _____ School _____

- ✓ Standardized Medication Authorization is complete with parent and prescriber affirmation signatures authorizing this student to self administer medication and keep his/her medication on person.
- ✓ Students Individual Health Care Plan is complete

_____ Parent/Prescriber Authorization matches prescription label and the label is intact.

_____ Medication is not expired: Product manufacturer expiration date _____

_____ Student has knowledge of medication administration and safety, including information addressed in his/her HCP.

_____ Student demonstrates knowledge, skill and experience of his/her chronic illness and medication. He/She verbalizes potential side effects and adverse reactions including when to contact the school nurse or prescriber.

Parent Prescriber Authorization for Self Administration of Medication:

_____ Student agrees he/she is accountable for safe and appropriate self administration of the authorized medication. He/ She has been informed of legal policies and requirements related to self administration of authorized medication and will not give or share medication with another person.

Parent Prescriber Authorization for Medication to Keep on Person:

_____ Student agrees he/she is accountable for safe and appropriate possession of the authorized medication. He/ She has been informed of legal policies and requirements related to possession of authorized medication and will not give or share medication with another person.

Parent/Guardian Signature _____ **Date:** _____

Student Signature _____ **Date:** _____

Parent Prescriber Authorization request that this student be allowed to possess and/or self-administer his/her own medication. I am reasonably assured that this student will safely and appropriately possess and /or self administer his/her prescribed medication as ordered in the school setting. This student currently demonstrates knowledge, skill and experience of his/her chronic illness and medication.

Nurse Signature: _____ **Date:** _____

Jefferson County Board Of Education

Diet Prescription for Meals at School

Name_____ DOB_____ Grade_____ ID#_____ School_____

Parent/Guardian_____ Phone#_____ Email_____

Information below to be completed by recognized medical authority.

Please list disability or medical condition that requires the student to have a special diet. Include a brief description of the major life activity affected by the student's disability. _____

_____

Diet Prescription (Check all that apply)

- ☐ Diabetic
- ☐ Reduced Calorie
- ☐ Other (describe) _____
- ☐ Increased Calorie
- ☐ Modified Texture

Foods Omitted (Please check food groups to be omitted.)

- ☐ Meat and Meat Alternates
- ☐ Milk and Milk Products
- ☐ Bread and Cereal Products
- ☐ Fruits & Vegetables
- ☐ Peanuts and Peanut Products
- ☐ Other_____

Substitutions (Please provide suggested substitutions for omitted foods or attach information.) _____

_____

Textures Allowed (Check the allowed texture)

- ☐ Regular
- ☐ Chopped
- ☐ Ground
- ☐ Pureed

Food Allergy (students with life threatening food allergies may require special meal preparation.) Is this allergy life threatening?_____

- ☐ Peanuts
- ☐ Soy
- ☐ Dairy
- ☐ Tree Nuts
- ☐ Fish
- ☐ Eggs
- ☐ Wheat
- ☐ Shellfish
- ☐ Other_____

Other Information Regarding Diet or Feeding (Please provide additional information on the back of this form or attach to this form.)

_____

_____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____ _____ _____

Physician/Recognized Medical Authority Signature | Office Phone # | Date

***This form should be resubmitted each school year.**

Rev. 7/15 kh

Return to: School Nurse
or
JCBE-Child Nutrition Programs
2100 18th Street South
Birmingham, AL 35209
Office: 205-379-2285 Fax to: 205-379-2313

Parents, **Revised 2019**

We will gladly assist your child with all medication needs, but the following state regulations must be adhered to. Remember all **medical forms** need to be completed **yearly**.

MEDICATION AT SCHOOL

1. **All medication**, whether prescription or over-the-counter, **MUST** have a signed "School Medication Prescriber/Parent Authorization" form for **EACH** medication.
2. **For prescription medications**, a physician signature AND a parent signature is required. NO PRESCRIPTION MEDICINES WILL BE GIVEN WITHOUT BOTH SIGNATURES ON THIS FORM.
3. **For over-the-counter medications** (including cough drops, ointments/creams, sunscreen (if student cannot apply themselves), Neosporin, vitamins, Visine, Motrin, Tylenol, Advil, Pepto Bismol, etc.) a "School Medication Prescriber/Parent Authorization" form is also needed. The parent's signature will allow medication to be given for **two weeks**. If medication is needed for a longer period of time, a physician's signature will be required. The parent must also provide the medication that the child needs to take. **Schools are not allowed to keep stock medicines such as Tylenol or Advil. No exceptions will be made.** No medication may be administered at school until **BOTH** signed permission and medication are obtained. While on field trips, parents are allowed to carry and administer medications to their student **ONLY**.
4. **All medication** must be brought in the original, **UNOPENED** container. Prescription medication must be brought in a current pharmacy labeled container with student's name, physician name, name of medication, strength, dosage, time interval, and route. **No medication will be accepted loose in a plastic bag or unidentifiable container.**
5. All medication is to be delivered **by the parent** to the nurse or an adult in the office. **Do not send medication to school with your student.** We do not want to place your child in the position of being responsible for medication until the appropriate school personnel can take possession of it. No student will be permitted to carry or possess any type of medication, whether Prescription or Over-the-Counter, on his/her person at any time **(except EMERGENCY MEDICATIONS and approved medications prescribed for self-administration)**. **Students found possessing medication will be subject to disciplinary action under Section 3.07 of the Code of Student Conduct.**
6. **Controlled medications**, like Ritalin, **must** be counted when brought to school. Please wait while the nurse or school employee counts the medication. The parent and school employee will be required to sign the back of the Medication Administration form verifying the medication count.
7. School personnel will not administer natural remedies, herbs and/or nutritional supplements without the explicit order of an authorized prescriber, parent authorization, verification that the product is safe to administer to children in the prescribed dosage and reasonable information regarding therapeutic and untoward effects.
8. If your child has any **food allergies**, you will need to have a "Diet Prescription for Meals at School" form completed and signed by **both** the physician and parent to turn into the school nurse.

HOW SICK IS "TOO SICK" TO ATTEND SCHOOL?

We follow these guidelines in order to maintain the healthiest environment possible for all students.

FEVER: Temperature of 100 or above. Child should remain fever free without fever-reducing medication for 24 hours.

VOMITING or DIARRHEA: Your child should not attend school if they have vomited in the last 12 hours OR have diarrhea or have had diarrhea in the last 12 hours.

UNDIAGNOSED RASH: Your child should not attend school until rash has been diagnosed and treated for 24 hours.

PINK EYE: This is highly contagious. Your child should be treated for 24 hours before returning to school.

HEAD LICE: Your child should not attend school if live bugs are present. Your child should be treated and have no live bugs prior to returning to school.

We can treat cuts, scrapes, bug bites, bumps, etc. with soap, water, bandaids, and ice packs **only**. Please keep our staff and the school nurse informed of **any health conditions** that could affect your child while at school. We want to provide the **best** care possible for your child!

Please feel free to call with any questions!