WEST GEAUGA LOCAL SCHOOL DISTRICT
8615 Cedar Road
Chesterland, OH 44026

MEDICATION GUIDELINES

In accordance with Ohio Revised Code, there are new stipulations for administering all over-the-counter and prescription medications at school. The following are now **required**:

1. All medications can only be dropped off by an adult.

2. All medications must be in the original container and all prescription medications must have the pharmacy label.

3. All medications must now be counted upon arrival. So please have all over-the counter medications in a new, unopened original container.

4. Medications will not be accepted until the Medication Administration Record Form has been completed by the parent **and** the physician. The Medication Drop-Off and Pick-Up Instruction Form must also be completed. They must be turned in together.

5. The Medication Administration Record Form must be filled out completely.

6. Overnight / day long field trips now require a separate container with pharmacy label on all prescription medications. Only the amount of medication required for the duration of the trip is allowed in the container.

7. Middle school and high school students who are able to carry their own rescue inhalers and EpiPens must still have the Medication Administration Record Form completed by the parent and the physician. Students who carry EpiPens MUST have a back-up EpiPen in the clinic

The Medication Administration Record Form and the Medication Drop-Off and Pick-Up Instruction Form can be downloaded from the district website. Hard copies are also available at each district building.

WEST GEAUGA LOCAL SCHOOL DISTRICT

MEDICATION ADMINISTRATION RECORD (MAR)

8615 Cedar Road, Chesterland, OH 44026
Fax: High School 440-729-5959 / **Middle School** 440-729-5909 / **Lindsey** 440-729-5989 / **Westwood** 440-729-5924

STUDENT INFORMATION

STUDENT NAME			DATE OF BIRTH
ADDRESS			
SCHOOL	GRADE	TEACHER	SCHOOL YEAR
LIST ANY KNOWN DRUG ALLERGIES/REACTIONS			

PRESCRIBER AUTHORIZATION

NAME OF MEDICATION	CIRCUMSTANCE FOR USE	
DOSAGE	ROUTE	TIME INTERVAL
DATE TO BEGIN MEDICATION	DATE TO END MEDICATION	

CIRCUMSTANCES FOR USE

SPECIAL INSTRUCTIONS

TREATMENT IN THE EVENT OF ADVERSE REACTION

EPINEPHRINE AUTO-INJECTOR
- Not Applicable
- Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

ASTHMA INHALER
- Not Applicable
- Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.

PROCEDURES FOR SCHOOL EMPLOYEES IF THE STUDENT IS UNABLE TO ADMINISTER THE MEDICATION OR IF IT DOES NOT PRODUCE THE EXPECTED RELIEF

POSSIBLE SEVERE ADVERSE REACTION(S) PER ORC 3313.718
A. TO THE STUDENT FOR WHOM IT IS PRESCRIBED (THAT SHOULD BE REPORTED TO THE PRESCRIBER)

POSSIBLE SEVERE ADVERSE REACTION(S) PER ORC 3313.718
A. TO THE STUDENT FOR WHOM IT IS PRESCRIBED (THAT SHOULD BE REPORTED TO THE PRESCRIBER)

B. TO A STUDENT FOR WHOM IT IS NOT PRESCRIBED WHO RECEIVES A DOSE

OTHER MEDICATION INSTRUCTIONS
DOES MEDICATION REQUIRE REFRIGERATION? • YES • NO IS THE MEDICATION A CONTROLLED SUBSTANCE? • YES • NO

PRESCRIBER SIGNATURE	DATE	PHONE	FAX
PRESCRIBER NAME (PRINT)			

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler

PARENT/GUARDIAN AUTHORIZATION

☒ I authorize an employee of the school board to administer the above medication. ☒ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☒ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☒ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☒ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

PARENT/GUARDIAN SIGNATURE	DATE	#1 CONTACT PHONE	#2 CONTACT PHONE

PARENT/GUARDIAN SELF-CARRY AUTHORIZATION

☐ *For Epinephrine Auto Injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

☐ *For Asthma inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

PARENT/GUARDIAN SIGNATURE	DATE	#1 CONTACT PHONE	#2 CONTACT PHONE

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MEDICATION DROP-OFF / PICK-UP INSTRUCTIONS
for Parent/Guardian

DEAR PARENT OF: _____
STUDENT NAME

IF YOUR CHILD MUST TAKE MEDICATION DURING THE SCHOOL YEAR, HE/SHE MUST HAVE THE FOLLOWING:

PART 1: DROP-OFF AND PICK-UP INSTRUCTIONS FOR PARENTS

Medication drop-off instructions

Parent/guardian must drop off medication (or designate a responsible adult) to deliver the medication to school designated location.

The Ohio Revised Code and school district policy state you must have:

- Written medication authorization record from your child's licensed health care prescriber and signed permission from the parent/guardian (school will provide necessary forms).
- Pharmacy-labeled original bottle or original container with student name and grade of non-prescription.

Other Comments:

Medication pick-up instructions

If your child's medication is discontinued **during** or **after the end of the school year**, safe arrangements must be made for the safe return. Please indicate your choice of how you prefer us to handle the return of your child's medication once discontinued by the health care prescriber or at the end of the school year.

- I will come into the school office/clinic when my child's medication is discontinued by the health care prescriber or it is the end of the school year.
- I request that the school dispose of any medication remaining after the last day of school. (If this form is not returned, medication will be properly discarded _____ week(s) after school ends.)

I give the school permission to send my child's:

- Epinephrine auto-injector or
- Asthma inhaler home with my child on this date _____. I assume all responsibility for the medication after it leaves the school.

Parent/Guardian Signature	Date	#1 Contact phone	#2 Contact Phone

PART 2: FOR SCHOOL NURSE/PERSONNEL ONLY

Your child, _____ has _____ of _____ left in the clinic.
amount left medication name

Please follow all medication instructions above to ensure safe medication practice.

School nurse/School personnel signature	Title	Phone	Date

Please contact the school for any questions or concerns