

# STUDENTS

## Series 500

Policy Title Administration of Medication to Students Code No. 507.02

Some students may need prescription and nonprescription medication to participate in their educational program.

Medication shall be administered when the student's parent or guardian (hereafter "parent") provides a signed and dated written statement requesting medication administration and the medication is in the original, labeled container, either as dispensed or in the manufacturer's container.

When administration of the medication requires ongoing professional health judgment, an individual health plan shall be developed by an authorized practitioner with the student and the student's parent. Students who have demonstrated competence in administering their own medications may self-administer their medication. A written statement by the student's parent shall be on file requesting co-administration of medication, when competence has been demonstrated. By law, students with asthma or other airway constricting diseases may self-administer their medication upon approval of their parents and prescribing physician regardless of competency.

Persons administering medication shall include the licensed registered nurse, physician, persons who have successfully completed a medication administration course, or to be an authorized practitioner, including parents. A medication administration course and periodic update shall be conducted by a registered nurse or licensed pharmacist, and a record of course completion kept on file at the agency.

A written medication administration record shall be on file including:

- student's name;
- date;
- prescriber or person authorizing administration;
- medication;
- medication dosage;
- administration time;
- administration method;
- signature and title of the person administering medication; and
- any unusual circumstances, actions or omissions.

Medication shall be stored in a secured area unless an alternate provision is documented. Emergency protocols for medication-related reactions shall be posted. Medication information shall be confidential information.

### **Legal Reference:**

Iowa Code §§ 124.101(1), 147.107, 152.1, 155A.4(2), 280.16, 280.23 (2009).

Education {281} IAC §41.404(3).

Pharmacy {657} IAC §8.32(124, 155A).

Nursing Board {655} IAC §6.2(152).

### **Cross Reference:**

506.00 Student Records

507.00 Student Health and Well-Being

603.03 Special Education

607.02 Student Health Services

Date of Adoption: June 10, 2013 (Revised)

**AUTHORIZATION ASTHMA OR AIRWAY CONSTRICTING MEDICATION  
SELF-ADMINISTRATION CONSENT FORM**

Board Policy 507.02

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Student's Name (Last, First, Middle)

Birthdate

School

Date

In order for a student to self-administer medication for asthma or any airway constricting disease:

- Parent/guardian provides signed, dated authorization for student self-administration.
- Physician (person licensed under chapter 148, 150, or 150A, physician, physicians' assistant, advanced registered nurse practitioner, or other person licensed or registered to distribute or dispense a prescription drug or device in the course of professional practice in Iowa in accordance with section 147.107, or a person licensed by another state in a health field in which, under Iowa law, licensees in this state may legally prescribe drugs) provides written authorization containing:
  - purpose of the medication,
  - prescribed dosage
  - times, or;
  - special circumstances under which the medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container containing the student name, name of the medication, directions for use, and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, a student with asthma or other airway constricting disease may possess and use the student's medication while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, such as while in before-school or after-school care on school-operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established Iowa Code § 280.16.

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Medication

Dosage

Route

Time

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Purpose of Medication & Administration / Instruction

**AUTHORIZATION ASTHMA OR AIRWAY CONSTRICTING MEDICATION  
SELF-ADMINISTRATION CONSENT FORM**

Board Policy 507.02

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Special Circumstances	Discontinue/Re-Evaluate Follow-up Date
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Physician Signature	Date
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Physician Address	Emergency Phone
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- I request the above-named student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or interfering with a student's self-administration of medication.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy (FERPA).
- I agree to provide the school with back-up medication approved in this form.
- Student maintains self-administration record.

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Parent/Guardian Signature (Agreed to above statement)	Date
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Parent/Guardian Address	Home Phone
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Business Phone

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Self-Administration Authorization Additional Information

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**PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION  
OF PRESCRIPTION MEDICATION TO STUDENTS**

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Student's Name (Last, First, Middle)	Birthdate	School	Date
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School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

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Medication/Health Care	Dosage	Route	Time at School
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Administration Instructions

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Special Directives, Signs to Observe and Side Effects

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Discontinue/Re-Evaluate  
Follow-up Date

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Physician Signature

Date

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Physician Address

Emergency Phone

I request the above-named student carry medication at school and school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

**PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION  
OF PRESCRIPTION MEDICATION TO STUDENTS**

Board Policy 507.02

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Parent/Guardian Signature

Date

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Parent/Guardian Address

Home Phone

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Business Phone

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Authorization Form

**PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION  
OF NON-PRESCRIPTION MEDICATION TO STUDENTS  
NAMELY TYLENOL OR IBUPROFEN**  
Board Policy 507.02

June 2013

The undersigned are the parent(s), guardians(s) or person(s) responsible for

\_\_\_\_\_  
Student's Name (Last, First, Middle)

\_\_\_\_\_  
Grade

Attendance Center:

George Elementary

Little Rock Elementary

G-LR Middle School

G-LR High School

Tylenol

Ibuprofen

\_\_\_\_\_ Dosage/mg.

Beginning on \_\_\_\_\_ and continuing through \_\_\_\_\_  
Date Date

\_\_\_\_\_  
Special Instructions to Medication Administrator

Person(s) authorized to administrator medication: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian (PRINT NAME)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (SIGNATURE)

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Alternate Phone Number