MENDOCINO COUNTY OFFICE OF EDUCATION
WARREN GALLETTI, SUPERINTENDENT OF SCHOOLS
2240 Old River Road ● Ukiah, CA 95482-6156 ● 707 467-5001 ● Fax 707 462-0379

CHECKLIST FOR STAFF TO ASSIST STUDENT WITH SELF-ADMINISTRATION OF MEDICATION

STUDENT NAME: _____ **DATE**: _____

Staff Initials

_____ 1 I have read *Board Policy and Regulation 5035.00 – Student Medication* regarding the administration of medication to students.

_____ 2 *Authorization for Staff to Assist Student with Self-Administration of Medication* form signed by parent/guardian and doctor.

_____ 3 Nurse reviews the form and assures that dosage and instructions are clear and understandable. If the dosage and instructions are not clear, call doctor for clarification.

_____ 4 Medical file and log setup, preferably by the nurse, if unavailable nurse will check log within five (5) working days.

_____ 5 Medication received in accordance with policy (in pharmacy bottle and labeled consistent with doctor instruction on the authorization form), stored in proper location and noted on a log. If a controlled substance, then also a count of the medication is conducted. [Note: All medication is to be kept locked-up.]

_____ 6 Notify office staff, teacher(s) and other appropriate staff members and review confidentiality requirements with them.

_____ 7 Staff is asked to indicate school events for which the student will need support.

_____ *8* Administrator, in consultation with nurse, designates the staff member(s) who will administer medication. Set up support for each event – see *Board Exhibit 5035.00c – School Activity and Field Trip Checklist.*

_____ 9 Nurse insures that staff member reads the *Student Medication* policy and regulation, is trained, capable of following proper medical practice, and fills out the log. Nurse signs log signifying same.

_____ 10 Log is filled out after each dose is given including notation of the staff member who administered or failed to administer the medication.

_____ 11 Parent(s) receive/sent a copy of the *Student Medication* policy and regulation.

Checklist for Staff to Assist Student with Self-Administration of Medication (continued)

Staff Initials

_____ 12 Parent(s) receive/sent notification that additional 72-hour supply of each medication is needed in case of emergency in order to prevent adverse effects.

_____ 13 Place a copy of the *Authorization for Staff to Assist Student with Self-Administration of Medication* form in emergency/disaster plan.

_____ 14 When received, place 72-hour supply in zip-lock bag and have ready for emergency/disaster. [This is in everyone's emergency plan, but is never followed as it requires an additional prescription, which the insurance companies will not pay for. It is a problem that has yet to be resolved in the school community.]

_____ 15 Place this *Checklist* in the medical file.

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Students **BE 5035.00a**

AUTHORIZATION FOR STAFF TO ASSIST STUDENT WITH SELF-ADMINISTRATION OF MEDICATION

(A separate form must be completed by physician for each medication)

Student Name: _____

Date of Birth: _____ School Year: _____

Physician's Authorization of Medication

Name of Medication:	
Dosage:	
Time and Route:	
Side Effects:	
Reason for Medication:	
Conditions Under Which Medication Is To Be Used:	

Physician Name: (please print)	
Physician Signature:	
Date Signed:	
Physician Address:	
Physician Phone:	

IMPORTANT NOTE**: All medication must be in the container in which it was purchased with the pharmacy label that includes dosage, instructions, and the prescribing physician's name. The medication must be prescribed for the student to whom it will be administered.* ***No medications (including over-the-counter medications) will be given at school without a current prescription from a physician.

Parent/Guardian Authorization for Staff to Assist Student with Self-Administration of Medication

I am the legal guardian for the above-named student. I have received a copy of MCOE Board Policy/Regulation 5035 – Student Medication. I give permission for an authorized staff member of MCOE to assist my child with the self-administration of medication as indicated on this form by my child's physician. I give permission for the school administrator, agency nurse, or other designated personnel to consult with the above-named physician regarding any questions about this Authorization.

I understand that it is my responsibility to provide MCOE with all necessary medication, supplies and equipment that are needed in order for the student to receive the required medication. I also agree to provide written notification to the school nurse, other duly qualified supervisor of health, or site administrator if there is a change in the student's medication (i.e., change in dosage, frequency, type of medication), health status, or authorized health-care provider.

_____ _____
Parent/Guardian's Signature Date

_____
Parent/Guardian's Printed Name

IMPORTANT: THIS AUTHORIZATION FORM MUST BE DELIVERED IN PERSON BY THE PARENT OR FAXED. TELEPHONED, STUDENT-DELIVERED OR EMAILED AUTHORIZATIONS WILL NOT BE ACCEPTED. ***NO EXCEPTIONS.***

REVIEWED AND APPROVED

_____ _____
School Nurse's Signature Date

MENDOCINO COUNTY BOARD OF EDUCATION

Adopted: May 11, 2009