Teays Valley Local School District
385 Viking Way
Ashville, Ohio 43103

School Medication Guidelines

Scheduling of medication outside of school hours is encouraged. When that is not possible a specific policy must be followed. If your child needs to take prescription medication during school hours, please be aware written permission from the parent or guardian, physician's verification/authorization, and identification of the medication, dosage, and time interval it is to be taken.

All medication must be received in the container in which it was dispensed by the physician or pharmacist.

For over-the-counter medication, the student should bring the medication to the office in its original container and clearly marked with the student's name. Written permission from the parent will also be required before any over-the-counter medication is administered by a school employee. All medications will be kept in a locked cabinet in the school office/clinic, unless special circumstances justify an exception.

For prescribed medications, parents/guardians are responsible for the safe delivery of the medication to the school office. ***For controlled substances***- it is ***required*** that the parent/guardian or designated adult must bring in the medication to the school office and review with school staff. Specific instructions on how and when the medication is to be given will be reviewed at this time. Parents/guardians need to instruct the child as to the medication schedule and when the child is to report to the office. Parents will assume responsibility of notifying the school if the medication orders have changed.

Parents must understand that they are responsible for picking up any leftover or expired medication at school and that the medication will be disposed of on/after the last day of school if not collected by the parent- unless the parent has made specific arrangements with school personnel.

Medication forms are available in the school office or on the Teays Valley website at www.tvsd.us

The school physician will serve as health consultant and will provide written medication 'standing orders' for general and emergency care. In the event that a child needs NON-Prescription medication for minor ailments at school, the school nurse or her designee may dispense any of the following OTC medication under the guidelines of the school physician standing orders: Ibuprofen, Acetaminophen, Benadryl, Tums, Imodium A-D, Robitussin or First Aid/Antiseptic topical medication. This would be done with the parental signed permission, which would be indicated on the school emergency authorization form that is given to parents annually.

Thank you,
Teays Valley Nursing Staff

Teays Valley Local School District
Prescribed Medication Authorization

Name________________________________ Phone________________________________

Address____

Birthdate_____________ School________________________ Grade/Class____________

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO RECEIVES OR USES PRESCRIBED MEDICATIONS IN SCHOOL: ***BOTH PORTIONS OF THIS FORM MUST BE COMPLETED.***

1. I am requesting permission for the student named above to receive or use medication according to the doctor's' verification on this form. I have instructed my child to report to the school office to receive the medication at the designated time. I will keep an adequate supply of medication at school.
2. I will assume responsibility for safe delivery of the medication to the school office.
3. I will call the school office and send a written note if my child is taken off of this medication.
4. I will bring in a completed, prescribed medication form for any dosage/medication changes.
5. I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

____ ________________________ ______________

Signature of Parent/Guardian Phone Number Date

****** All medication must be in original pharmacy dispensed containers. Labels must match instructions from physician on this form.**

PHYSICIAN'S STATEMENT

To the physician:

The Teays Valley Board of Education urges you to schedule the taking of medication by students at times outside of school hours. When that is not possible, the receiving or use of medication will be permitted, as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

____ ________________________________

Medication **Dosage**

Form of medication: Tablet/Capsule, Liquid, Inhaler, Nebulizer, other_________________________________

Diagnosis for which medication is prescribed ____

Medication to be taken at the following time(s)____

Instructions/Precautions/ adverse effects that need reported ______________________________

Prescription beginning date______________ **Prescription expiration date**________________

Date form completed ___________________ **Physician Signature**_____________________________

Physician Printed name, address, phone____

The school will report concerns about medications or disease to the above physician. A new form must be completed for each dosage/medication change. **<u>A new form must be completed for each medication- *EVERY SCHOOL YEAR.*</u>**

REV 2/17

Teays Valley Local School District
385 Viking Way
Ashville, Ohio 43103

Request That Student Carry and Administer Own Medication

1. Physician's Section

______________________________ is under my care and should be allowed to carry and
Student Name
administer his/her personal medication ____
Medication Name , Dose, Time to Administer

Dosage, Frequency, and Time of Administration

The student has been instructed and demonstrates knowledge of the proper circumstances in which this medication should be administered, as well as the proper care, storage and administration of the above indicated medication.

Possible side effects or severe adverse reactions to watch for: _________________________
____

Medication Starting Date _________________ Expiration Date is end of current school year.

Physician's Signature ___________________ Physician's Phone _____________________

Date ____________

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2. Parent's Section

I request and give my permission for my child to self administer his/her medication in keeping with Section 1 above. Further, I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

I further agree to submit a revised statement signed by the physician who has prescribed the medication described in Section 1, in the event that I become aware that any of the information set forth in that Section has changed. I have read and understand the policy of the Teays Valley Local Schools for the administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication by school personnel.

Student Name _________________________ School ______________ Grade ________

Phone ______________________ Address ______________________________________

Parent/Guardian Signature _____________________________ Date _________________

REV 2/2015

Asthma Action Plan

Name ______________________________ DOB ____/____/______

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) ______________________________

Peak Flow Meter Personal Best ________

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it
	____________	____________	____________
	____________	____________	____________

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity

☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add ______________________ ☐ Change to ______________________

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, ______________________ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Emergency Contact Name ______________________ Phone (______) ______-______

Healthcare Provider Name ______________________ Phone (______) ______-______

1-800-LUNGUSA | LUNG.org

Date ____/____/______