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| <b>TOPEKA PUBLIC SCHOOLS</b>  | <b>REGULATION NUMBER: 8325-1</b>                             |
| <b>SUBJECT:</b><br><br><b>SUPERVISION OF<br/>STUDENT MEDICATION</b> | <b>DATE OF ISSUE: 06/18/80</b>                               |
|   | <b>REVISIONS: 02/21/97; 07/19/02; 03/20/09;<br/>12/17/18</b> |
|   | <b>PREPARING OFFICE:<br/>INSTRUCTION AND LEARNING</b>        |

**I. PURPOSE:**

To implement and establish procedure for students taking medication under supervision of designated personnel.

**II. PERSONNEL AFFECTED:**

- A. Building Principal or Designee
- B. Parent or Lawful Custodian
- C. Student
- D. Nurse or Designee
- E. Teacher

**III. RESPONSIBILITY:**

- A. When prescription medication is to be taken by a student during the school day, the parent or lawful custodian is responsible for submitting the completed form, "Request to Administer Medication", No. 8709-20. Except, a physician's signature is not required when an antibiotic is prescribed for less than a thirty (30) day period.
- B. When an over the counter medication is to be taken by a student during the school day, the parent or lawful custodian is responsible for submitting the completed form, "Request and Permission to Supervise the Taking of Medication at School", No. 8709-00.
- C. Prescribed or over the counter medication may be taken by a student under supervision at school with the signed consent of the nurse or his/her designee.
- D. The building principal is responsible for ensuring that the school nurse is informed prior to all medication being taken.

**SUPERVISION OF STUDENT MEDICATION (Continued)**

- E. Parents or lawful custodians are responsible for obtaining any medication which has been prescribed by a licensed physician who has established the need of the student to take such medication during school. All medication must be brought to the nurse by the parent or lawful custodian. In the nurse's absence, medication shall be received and secured by the principal or any other adult staff member to whom responsibility has been delegated in writing by the nurse.**

**IV. PROCEDURE FOR PRESCRIPTION MEDICATION:**

- A. Medication prescribed by a licensed physician to be taken by a student under the supervision of school personnel:**
  - 1. The parent or lawful custodian shall notify the nurse of the student's need to take prescribed medication at school.**
  - 2. The nurse shall notify the principal of student's medication need.**
  - 3. The parent is responsible for completing the written request form and obtaining the signature of the physician for supervision of such prescribed medication at school prior to the student taking the medication at school.**
    - a. A copy shall be placed in student's cumulative folder.**
    - b. The original copy of the form will be kept on file in the health clinic and will serve as the record.**
  - 4. Such prescription medication shall be placed in the possession of the nurse or the nurse's designee, who is responsible for its safekeeping.**
  - 5. The parent or lawful custodian shall confer with the nurse. The nurse will confer with the principal, student and other designated staff. During this conference the following items will be discussed, and mutual agreement with regard to these items will be reached:**
    - a. Supervision of the student taking said prescribed medicine by nurse or designee.**
    - b. A secure and locked holding place for the medication.**
    - c. The parent must provide the medication in the original container with the current pharmacy label showing the student's name, name of medication, amount of single dosage, name of physician, and date.**
    - d. A written request by the physician and parent is required on Form No 8709-10 when a prescribed asthma inhaler is to be kept on the student's person or in the student's locker. The Topeka Public Schools is not responsible for safeguarding the student's asthma inhaler.**
    - e. A written request by the physician and parent is required on Form No. 8709-12 when a prescribed epi-pen injection is to be kept on the student's person or in the student's locker. The Topeka Public Schools is not responsible for safeguarding the student's epi-pen**

**SUPERVISION OF STUDENT MEDICATION (Continued)**

**injection.**

- f. A written request by the physician and parent is required on Form No. 8709-14 when a prescribed Glucagon injectable is to be kept on the student's person or in the student's locker. The Topeka Public Schools is not responsible for safeguarding the student's Glucagon injection.**

- B. The above-mentioned procedures with regard to prescribed medications are subject to and contingent upon the written approval of the principal or the principal's designee. It should be clearly understood that the principal or the principal's designee is not required to enter into the agreement. Further, the principal at his/her discretion may, by written notice to the parent or lawful custodian, withdraw such approval at any time subsequent to the signing of the agreement.**

**V. PROCEDURE FOR OVER THE COUNTER MEDICATION**

**The procedure for over the counter medication will be the same as prescription medication with the following exceptions:**

- A. Such medication may or may not be allowed at the discretion of the building nurse, principal or his/her designee.**
- B. Current pharmacy label is not required, although medication needs to be in its original container.**
- C. Physician's signature is not required for over the counter medication. However, some circumstances may require a physician's signature and may be requested by the supervising nurse.**

**SUPERVISION OF STUDENT MEDICATION (Continued)**

**REQUEST AND PERMISSION  
TO SUPERVISE THE TAKING OF MEDICATION AT SCHOOL**

I request and authorize \_\_\_\_\_  
(name of student)  
 to take at school or at any school activity under school supervision \_\_\_\_\_  
 \_\_\_\_\_ for \_\_\_\_\_ days.  
(medication and individual dosage)    (time of day)    (number of days)  
 Teacher: \_\_\_\_\_ Grade \_\_\_\_\_  
 Diagnosed Illness (Optional): \_\_\_\_\_  
 Prescription No.: \_\_\_\_\_ Name of Pharmacy: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Parent, Lawful Custodian or Person Acting as Parent)

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 I hereby request and give permission for \_\_\_\_\_  
(name of student)  
 to take the medication as indicated above. I understand this form merely reflects the request that the above-named student be allowed to take medication at school and that Topeka Unified School District No. 501 acknowledges this request and agrees to comply with the request if possible. I understand that Topeka Unified School District No. 501 does not, in any way, guarantee that the medication will be taken under supervision by the above-named student. I hereby release Topeka Unified School District No. 501, its officers and its employees, from any and all liability resulting from its failure to supervise the taking of the medication indicated above. I further hereby release Topeka Unified School District No. 501, its officers and its employees, from any and all responsibility for adverse effects of this medication and agree to indemnify them against any and all liability, loss, or damage they may incur or suffer as a result of the student named above taking or not taking the above medication.

\_\_\_\_\_  
 (Date) (Parent, Lawful Custodian or Person Acting as Parent)

Date of Approval \_\_\_\_\_ Approved by \_\_\_\_\_  
(Principal or Principal's Designee)

| DATE | TIME | DOSAGE | SUPERVISED BY | COMMENTS/<br>OBSERVATIONS |
|------|------|--------|---------------|---------------------------|
|      |      |        |               |                           |
|      |      |        |               |                           |
|      |      |        |               |                           |
|      |      |        |               |                           |

Distribution: Original--School Nurse; Pink--School File; Canary--Parent's Copy  
 Rev. 05/93; 02/97

Stockroom No. 8709-00

**SUPERVISION OF STUDENT MEDICATION (Continued)**

**TOPEKA PUBLIC SCHOOLS  
MEDICATION RELEASE FORM**

**Date:** \_\_\_\_\_

\_\_\_\_\_ has been instructed in the proper use of  
(Child's Name)

the \_\_\_\_\_ inhaler. We, \_\_\_\_\_ and  
(Physician)

\_\_\_\_\_, request that \_\_\_\_\_  
(Parent or Guardian) (Child's Name)

be permitted to carry the inhaler on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use of his/her inhaler.

We, the undersigned, absolve the school of any responsibility in safeguarding our child's inhaler.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse's Signature

\_\_\_\_\_  
Date

Distribution: Original - School Nurse; Pink - School File; Canary - Parent's Copy  
Stockroom No. 8709-10  
05/93

**SUPERVISION OF STUDENT MEDICATION (Continued)**

**NURSING SERVICES**

**REQUEST TO ADMINISTER MEDICATION**

**BOARD POLICY:**

**MEDICATION IS GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH A LAWFUL CUSTODIAN AND A PERSON WHO IS LICENSED TO PRACTICE MEDICINE AND SURGERY OR DENTISTRY IN THE STATE OF KANSAS AND IS PRESCRIBING THE MEDICATION. THESE WRITTEN REQUESTS ARE REQUIRED BEFORE ADMINISTRATION OF ANY MEDICATION IS INITIATED. IMPLEMENTATION OF THE REQUESTS MUST FOLLOW ALL APPLICABLE LAWS AND REGULATIONS.**

**Please provide all requested information:**

**Name of Pupil \_\_\_\_\_ Birth date \_\_\_\_\_**

**The above-named pupil needs to receive the following medication during his/her regular school attendance time:**

**Medication \_\_\_\_\_ Dosage \_\_\_\_\_**

**Requested starting date \_\_\_\_\_ Expected Duration \_\_\_\_\_**

**School time schedule of administration \_\_\_\_\_**

**Diagnosis \_\_\_\_\_**

**Other pertinent information \_\_\_\_\_**

**Date \_\_\_\_\_ Physician's signature \_\_\_\_\_**

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**THE FOLLOWING TO BE COMPLETED BY PARENTS/GUARDIANS:**

**I hereby certify that \_\_\_\_\_ has previously had at least one dose of the above-prescribed medication and did not have an adverse reaction from it. I request that this medication be administered at school as directed above. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the pupil because of administering such drug or because of mislabeled or altered product. I hereby authorize Topeka Public Schools Nursing Services personnel to exchange information regarding this request with \_\_\_\_\_, the above-named attending physician and with the pharmacy as identified on the affixed pharmacy label.**

**Date \_\_\_\_\_ Signature \_\_\_\_\_**

**Distribution: Original School Nurse; Pink - School File; Canary - Parent's Copy  
Stockroom No. 8709-20**

**4/93; 02/97**

**SUPERVISION OF STUDENT MEDICATION (Continued)**

**TOPEKA PUBLIC SCHOOLS  
MEDICATION RELEASE FORM**

Date \_\_\_\_\_

\_\_\_\_\_ has been instructed in the proper use of an Epi-pen injection.  
(Student's Name)

We, \_\_\_\_\_ (Physician) \_\_\_\_\_ (Parent(s) or Guardian(s))

request that \_\_\_\_\_ be permitted to carry the  
(Student's Name)

Epi-pen injectable on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate usage of his/her Epi-pen injection.

We, the undersigned, absolve the school from any responsibility in safeguarding our student's Epi-pen injection.

\_\_\_\_\_ Date \_\_\_\_\_  
(Parent's or Guardian's Signature)

\_\_\_\_\_ Date \_\_\_\_\_  
(Physician's Signature)

**RECEIVED AND APPROVED BY:**

\_\_\_\_\_ Date \_\_\_\_\_  
(Principal's Signature)

\_\_\_\_\_ Date \_\_\_\_\_  
(School Nurse's Signature)

Distribution: Original – School Nurse; Pink – School File; Canary – Parent's Copy Stockroom No. 8709-12  
3/02

**SUPERVISION OF STUDENT MEDICATION (Continued)**

**TOPEKA PUBLIC SCHOOLS  
MEDICATION RELEASE FORM**

Date \_\_\_\_\_

\_\_\_\_\_ has been instructed in the proper use of a  
(Student's Name)

Glucogen injection.

We, \_\_\_\_\_  
(Physician) (Parent(s) or Guardian(s))

request that \_\_\_\_\_ be permitted to carry the Glucagon  
(Student Name)

injectable on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate usage of his/her Glucagon injection.

We, the undersigned, absolve the school from any responsibility in safeguarding our Student's Glucagon injection.

\_\_\_\_\_ Date \_\_\_\_\_  
(Parent's or Guardian's Signature)

\_\_\_\_\_ Date \_\_\_\_\_  
(Physician's Signature)

**RECEIVED AND APPROVED BY:**

\_\_\_\_\_ Date \_\_\_\_\_  
(Principal's Signature)

\_\_\_\_\_ Date \_\_\_\_\_  
(School Nurse's Signature)

Distribution: Original – School Nurse; Pink – School File; Canary – Parent's Copy Stockroom No. 8709-14  
3/02