**Belmont Public Schools**
**Medication Administration Plan, Order and Parent/Guardian Consent**

## BELMONT PUBLIC SCHOOLS MEDICATION PROTOCOLS

**In compliance with Massachusetts General Law and for the safety of our students, this medication protocol will be strictly enforced.** Under Massachusetts General Laws (M.G.L.) chapter 112, § 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant to administer any medication, including over-the-counter medications.

Over-the-counter orders for ibuprofen, acetaminophen, and antacids are not needed as they are covered by standing orders from the BPS school physician, but must have parental permission. This permission must be renewed by the parent/guardian every year. These medications are provided by the district.

**The protocol for the administration of medications during school hours is as follows:**

Medication must be accompanied by a medication permission form signed by the student's physician and parent/guardian. For short-term medications (for ten days or less), such as antibiotics, the prescription bottle is acceptable for a physician's medication order; however, we still need a signed parental/guardian consent as indicated above.

**Medication must be supplied by the parent/guardian in the original pharmacy container.** Please ask your pharmacist to provide a second container and send only the quantity of medication needed to the school. We can't store more than a thirty-day supply.

Medication is kept locked in the nurse's office and is dispensed by the school nurse. For your child's safety and the safety of other students, students are not allowed to carry medication at school. **The only exceptions to this rule are epinephrine auto-injectors, insulin, inhalers, and pancreatic enzymes as allowed by Massachusetts regulations.** When a student must have immediate access to medication, the school nurse and parent/guardian will determine if the child can self-carry / self-administer. A medication permission form signed by the parent/guardian must be on file for self-administration of medication.

All medication orders must be for the treatment of a specifically diagnosed medical need and must be renewed at the beginning of each school year.

The parent/guardian may retrieve the medicine from school at any time during the school year. Any remaining medication must be picked up by the last day of school, as it will not be available for pickup during the summer. Medications can not be stored during the summer months.

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**Student name** _____ **DOB:** _____ **School** _____ **Grade:** ___ **Year** ___

To Be Completed by the Licensed Provider (Order may be attached to this form)

Name of Medication: _____ Date Ordered: _____ Duration of Order: _____

Dose: _____ Frequency: _____ Route: _____ Dose Time: _____

Known Food/Drug Allergies: _____

Diagnosis Related to This Prescription (if not confidential):_____

Administration Instructions (including timing, PRN parameters, precautions): _____

Special Storage Instructions: _____

Side Effect/Monitoring Requirements: _____

Other medications being taken by student: _____ (if not in violation of confidentiality)

Physician Name: _____ Physician Phone: _____

Physician Signature: _____ Date: _____

**To Be Completed by the Parent/Guardian**

**Parent/Guardian Permissions:**

- ☐ I give permission to the school nurse and/or designated unlicensed trained school personnel to administer this medication to my child
- ☐ *I understand that a parent/guardian must deliver medication in the pharmacy-labeled bottle or container.* The bottle must reflect the current order, description, and expiration date of the prescribed medication.
  **No more than a 30-day supply will be accepted.**
- ☐ It is my responsibility to pick up this medication when it is no longer needed at school. Medications not picked up within one week of the order's termination or by the last day of school will be disposed of properly.
- ☐ I give permission to the School Nurse to share information relevant to the prescribed medication administration as they determine appropriate for your child's health and safety

**Field Trip Administration Plan:** Unless otherwise noted, medication will be administered on field trips as long as required conditions are per district medication policy and 105 CMR 210.00

- ☐ Do not administer medication on field trips
- ☐ Self-administered by the student, with nurse approval per state regulations (self-administration medication authorization must be completed and attached).

**Early Release Days** - Unless otherwise noted, medication will be administered if school is in session at the scheduled time.

- ☐ I DO NOT want my child to receive their medication on early release days if school is in session during the scheduled time.

Parent/Guardian Printed Name: _____ Cell: _____ Other: _____

Parent/Guardian Printed Name: _____ Cell: _____ Other: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Contact (if parent/guardian is no available): _____ Phone Number: _____

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## School Nurse Medication Administration Plan:

**Administration Plan**

- ☐ Nurse Administers
- ☐ Self-Administration by student, with nurse approval per state mandate (self-administration medication authorization must be completed and attached)
- ☐ Delegated to unlicensed trained personnel

Delegated to (if applicable): _____ Back Up Delegation: _____

**Nursing Considerations** (monitoring and response, including missed dose or refusal); _____

**Emergency Action** (if applicable): _____ **Location of Medication Storage:** _____

**Early Release Days**: ☐ Yes, medication to be administered ☐ No, medication will not be administered at school

**Field Trips/School Activities (if applicable)**

- ☐ Medication not needed
- ☐ Medication Needed, Plan: _____

**Nurse Signature:** _____ **Date:** _____