School Nurse Fax #
913-993-_____

SHAWNEE MISSION
SCHOOL DISTRICT

# AUTHORIZATION FOR MEDICATION/PROCEDURE TO BE ADMINISTERED AT SCHOOL & FIELD TRIPS

## *Part A - Parent/Guardian to Complete*

Name of Student _____ Date of Birth:_____ Grade:_____ School Year: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school or on a field trip as indicated by my child's health care provider as described below and, if needed, on the addendum.
**I understand I must provide:** medication in its original labeled container and all necessary supplies.

I also give permission for communication between the school health professional and the medical prescriber related to the specific medication/treatment in question, including communication concerning:

1. The prescription or treatment itself - i.e., questions regarding dosage, method of administration, emergency procedures related to the treatment or procedure. 2. Implementation of the treatment in school - i.e., questions regarding modifications in the treatment order related to the school setting or student's academic schedule. 3. Student outcomes from the treatment - i.e., questions regarding observed side effects, possible negative reactions or observations of behavior changes. 4. Other pertinent issues related to the student's diagnosis, condition, or treatment.

On early dismissal/late start days, please select your choices: ____Do NOT administer on late start days. ____Do NOT administer on early dismissal days. ____Administer at adjusted lunch time. ____Administer at prescribed time.

_____ _____ _____
Parent/Legal Guardian Signature | Printed Name of Parent/Legal Guardian | Today's Date

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## *Part B - School Nurse/Health Care Provider to Complete*

**Medication/Treatment Orders:** (Please specify–if additional space is needed, a second page is attached to this form. The provider's school orders may also be sent for complete procedure details.)

| Medication/Treatment | Dosage/Route | Time/Frequency | Indication |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Special Instructions: _____

***For Diabetic Care at School: This student has demonstrated the skill level necessary to self-manage.*** ☐**Yes**

_____ _____ _____
Signature of Physician/APRN/PA | Printed Name of Physician/APRN/PA | Today's Date

_____ _____
Health Care Provider Phone Number | Health Care Provider FAX Number

**Medication & Procedure Orders and Consents must be renewed each school year.**

**Procedures** are specialized caretaking tasks that

- ❖ are prescribed by a health care provider that requires specialized training to implement.
- ❖ are necessary to enable the student to attend school and participate in school activities.

**The Registered School Nurse (RN)**

***Regarding over-the-counter and prescription medications***

- ❖ Must review all medication requests prior to initiating their administration.
- ❖ May designate and train non-nurse school staff members to administer medication.
  - ➢ When possible, medications should be taken prior to coming to school or after leaving school under parental supervision.

***Regarding procedures***

- ❖ Is responsible to review and process the request for the procedure.
- ❖ Is involved in the planning and provision of the services.
  - ➢ This planning will result in the development of an Emergency Action Plan (EAP) when indicated.
- ❖ May designate and train non-nurse school staff members to perform the procedure as outlined in K.A.R. 60-15-101-104

**The Parent/Legal Guardian**

- ❖ Must provide a new Authorization for Medication/Procedure at School form each school year
  - ➢ And any time a medication or procedure is changed

***Regarding over-the-counter and prescription medications***

- ❖ Must notify the school nurse immediately regarding changes. Any changes in dosage or schedule require a
  - ➢ New written order from the healthcare provider
  - ➢ Correctly labeled medication container

***Regarding procedures***

- ❖ Must notify the school nurse immediately regarding changes.
  - ➢ Changes require a new written order from the health care provider and review by the nurse before initiating.
- ❖ Is responsible for providing, maintaining, servicing, and replacing necessary equipment and supplies - i.e., syringes, tubing, ketone strips, etc.
  - ➢ Equipment must be correctly labeled with directions for use.
- ❖ Will communicate with the school nurse prior to the end of the year to discuss arrangements for transfer of equipment.

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## *Addendum*

***To be used if additional medications or treatments are ordered to be administered at school than space allows on the primary consent form.***

| Medication/Treatment | Dosage/Route | Time/Frequency | Indication |
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Special Instructions:_____

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_____ _____ _____

Signature of Physician/APRN/PA | Printed Name of Physician/APRN/PA | Today's Date

_____ _____

Health Care Provider Phone Number | Health Care Provider FAX Number